IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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January 2, 2008

Sandra Bruce
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, Idaho 83706

RE: St Alphonsus Regional Medical Center, provider #130007

Dear Ms. Bruce:

This is to advise you of the findings of the Medicare survey at St Alphonsus Regional Medical Center which was concluded on November 20, 2007.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 15, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

for RN

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/mlw

Enclosures

JAN 03 2008
COO OFFICE

Received 1/3/08
C Burnett
Vice President Patient Care

Saint Alphonsus

December 27, 2007

Sylvia Creswell
Idaho Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

Dear Ms. Creswell:

Attached please find Saint Alphonsus Regional Medical Center's plan of correction which is intended to address and rectify deficiencies cited during a Medicare/Licensure survey conducted on November 20, 2007. The documents included are:

1. Saint Alphonsus' plan of correction
2. Appendices A-M to the plan of correction
    a. Revised Restraint and Seclusion policy
    b. Restraint and Seclusion educational materials
    c. Letter to physician regarding prn restraint orders
    d. Letter to physician regarding signing restraint orders daily
    e. NDNQI Guidelines for data collection for pressure ulcers
    f. Pressure ulcer prevalence study results
    g. Pressure ulcer prevalence results for Saint Alphonsus compared to Trinity Health System
    h. Pressure Ulcer Performance Improvement Plan
    i. Revised Braden Scale for predicting Pressure Ulcer Risk and Skin Assessment policy
    j. Revised Wound and Pressure – Assessment and Care; Culture, Irrigation and Debridement policy
    k. Revised Nursing Admission Assessment form
    l. Pressure Ulcer education materials
    m. Skin Assessment audit form
    n. Restraint Audit form

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. The hospital takes the issues raised during the survey very seriously and have worked diligently to address each one.

We appreciate your thoughtful consideration of this plan of correction. We look forward to your acceptance of our plan and the revisit to verify our compliance.

1055 North Curtis Road
Boise, ID 83706-1370
Phone: (208) 367-2121
www.saintalphonsus.org

Please contact Aline Lee, RN, Director of Patient Safety and Regulatory Compliance at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Sandra B. Bruce

Sandra B. Bruce
President and CEO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130007	A. BUILDING _____ B. WING _____	11/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTER	1055 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the recertification and complaint investigation survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Rae Jean McPhillips, RN, HFS Patricia O'Hara, RN, HFS Acronyms used in the survey report include: CHF = Congestive Heat Failure CWOCN = Certified Wound-Ostomy-Continence Nurse DNS= Director of Nursing ED = Emergency Department EMR = Electronic Medical Record EMTEK = Hospital's Electronic Documentation System ET = Certified Wound-Ostomy-Continence Nurse consult ICU = Intensive Care Unit Nsg = Nursing PI = Program Improvement PRN = As Needed PT = Physical Therapist Pt = Patient RN = Registered Nurse SARMC = ST Alphonsus Regional Medical Center TIA = Transient ischemic attack UE = Upper Extremity	A 000	RECEIVED DEC 27 2007 FACILITY STANDARDS Please see following documents.	
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been	A 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra Bruce — TITLE — (X6) DATE: 12/21/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Plan of Correction
Response to Findings of November, 2007 Survey
Saint Alphonsus Regional Medical Center

Tag	Issue	Action	Responsible Person	Completion Date
A 000	INITIAL COMMENTS The following deficiencies were cited during the recertification and complaint investigation survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Rae Jean McPhillips, RN, HFS Patricia O'Hara, RN, HFS Acronyms used in the survey report include: CHF = Congestive Heart Failure CWOCN = Certified Wound-Ostomy-Continence Nurse DNS = Director of Nursing ED = Emergency Department EMR = Electronic Medical Record EMTEK = Hospital's Electronic Documentation System ET = Certified Wound-Ostomy-Continence Nurse consult ICU = Intensive Care Unit Nsg= Nursing PI = Performance Improvement PRN = As Needed PT = Physical Therapist Pt = Patient RN = Registered Nurse SARMC = ST Alphonsus Regional Medical Center TIA = Transient Ischemic attack UE = Upper extremity			
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION			

	Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient and others from harm. The STANDARD is not met as evidenced by: based on review of clinical records and staff interview, it was determined the hospital failed to ensure restraints would only be used when less restrictive interventions had been determined to be ineffective to protect the patient from harm. This was the case for 3 of 4 sampled patients (#s 42, 43, and 44), who had been placed in restraints, to protect from harm. The findings include: 1. The policy "Restraints and Seclusion" not dated stated "Ill. Initiation of Restraint/Seclusion: B...a regist4ered nurse may initiate restraint/seclusion based on an appropriate assessment of the patient". The items to be assessed, including the use of less restrictive measures, were not specified in the policy. The Director of Patient Safety, interviewed on 11/20/07 at 10:00 AM, stated specific assessments to ensure consistency for all nurses, had not been developed. 2. The hospital failed to ensure less restrictive interventions had been determined to be ineffective prior to the use of restraints, for 3 of 4 sampled patients (#'s 42, 43, and 44) who had been placed in restraints. Examples include: *Patient #42 was a 90 year old female who was admitted to the hospital on 10/19/07 with diagnosis of urinary tract infection and Alzheimer's disease. She was discharged on 10/22/07. An order on 10/19/07 at 2:00 PM stated that the patient was unsafe to be out of bed and was attempting to get out of bed. A vest restraint was ordered. The restraint was re-ordered on 10/20, 10/21, and 10/22/07. From 2:00 PM on 10/19/07, the patient remained restrained during her entire stay at the hospital. No nursing note was documented specifically describing the patient's behavior that indicated the need for restraints or what specific less restrictive measures had been tried prior to the use of restraints. Nursing notes at 8:00 PM on 10/19/07 stated the patient was restless and trying to get out of bed. At 4:00 AM on 10/20/07 the patient was	**The "Restraint and Seclusion" policy has been revised to include a description of the items to be assessed before initiating restraints. Please see Appendix A, Restraint and Seclusion policy, section II. B. The policy requires documentation of the less restrictive measures considered or attempted prior to applying or continuing restraints. Please see Appendix A, section IV. B. Please note that policies include the original, review, and revision dates at the end of the policy.** **Education for staff regarding use of restraints and seclusion was accomplished through a train-the-trainer approach. Trainers were identified for each unit. The unit trainers attended one of three sessions conducted by the clinical**	**Aline Lee, Director of Patient Safety and Regulatory Compliance** **Aline Lee, Director of Patient Safety and Regulatory Compliance**	**12/12/07** **Train-the-trainer sessions were conducted on 12/12/07, 12/14/07, and**

	noted to be sleeping in a chair. The patient was confused but no restlessness or behavioral problems were documented through 3:13 PM on 10/22/07 when she was discharged. Nurses chose letters from a computerized list to indicate which less restrictive measures had been utilized. When the restraint was initiated on 10/19/07 at 2:00 PM, the nurse chose "Alarm" from a computerized list which documented "A" on the patient's medical record. Other letters were documented at times throughout the patient's stay which meant "Medication, Reality Orientation, Diversionary Activity, Education/Limit Stetting, and Modification of Environment. The letters did not describe what the less restrictive measure meant or what the patient's response was to the intervention. For example, Modification of Environment (E) was documentation 4 times in the patient's record. It was not documented what kind of modification tot he patient's environment had been made or what the patient's response was. "Education/Limit setting" was documented 3 times. It was not documented what this meant or whether it was effective. The 6 West Charge Nurse, where the patient resided during her stay, was interviewed at 11:00 AM on 11/8/07. She reviewed the record and stated a specific assessment of the need fro restraints, including the use of less restrictive measures and their effectiveness, was not documented in the record. *Patient #44 was an 86 year old male who was admitted to the hospital on 9/30/07 with a diagnosis of a left-sided subdural hematoma. He was discharged from the hospital on 10/8/07. A verbal order for wrist and chest restraints, obtained on 10/2/07 at 11:30 AM, documented the patient was attempting to get out of bed and had cognitive impairment. On 10/4/07 (untimed) an order for vest, wrist and ankle restraints documented the patient continued to attempt to get out of bed and was cognitively impaired. Additionally, contained in the record was an undated and untimed order for v3est, wrist and ankle restraints with no documented reason for restraints. There was no documentation in the record for 10/2/07 that indicated the reason for the implementation of wrist restraints. On 10/3/07 at 4:00 AM, it was documented that ankle restraints were used in addition tot he vest	**educators. At these sessions, the trainers received packets containing flyers, revised policies, a summary of the changes to the electronic medical record (EMR) or paper forms, and talking points for use at staff meetings, in-services, posters, bulletin boards, or other forms of communication. In addition to the trainers, other staff were available to round on units to provide one-to-one coaching and evaluation of restraint use and documentation. Education focused on the following key points:** **1. Ongoing assessment of the need for restraint and removal of restraints when less restrictive measures are effective.** **2. Documentation that describes the patient's behavior and condition that necessitates the use of restraint.** **3. Specific documentation of the less restrictive measures attempted or considered using the pick lists as well as narrative entries if necessary to describe the specific interventions.**		**12/1/07. Unit education completed by 12/27/07.**

	and wrist restraints. Nursing notes, dated 10/3/07 at 6:50 AM, documented the patient was "increasingly agitated, calmed with PRN pain meds and Haldol..." There was no documentation in the record for 10/3/07 that indicated the reason for the implementation of ankle restraints. On 10/3/07 at 4:00 PM, nursing notes documented the vest restraint was removed but that the wrist and ankle restraints were continued. There was no documentation in the record that indicated the condition of the patient had changed to warrant the removal of the vest restraints or continued use of the wrist and ankle restraints. On 10/4/07 at 8:00 AM, nursing notes documented the wrist and ankle restraints were removed and that the vest restraint was reapplied. The vest restraint was discontinued on 10/7/07 at 8:00 AM. On 11/8/07 at 11:45 AM, the 6 West Charge Nurse and the Director of Patient Safety reviewed the record. They confirmed a specific assessment of the use of less restrictive measures was not documented by nurses who implemented and maintained the restraints. *Patient #43 was a 72 year old male with a diagnosis of Stage III multiple myeloma. He was hospitalized for malnutrition and uncontrolled pain on 10/18/07 and expired on 10/27/07. On 10/23/07 he required intubation and was transferred to the ICU. On 10/24/07 at 2:00 AM bilateral wrist restraints were initiated for reasons, checked from a computer list, of Unsafe OOB (unsafe out of bed), ImpCogntn (impaired cognition) and RemovLne (removing a line). These remained in place through 10/25/07 at 9:00 PM and continued through 10/26/07 at 8:00 PM. There was no documentation in the EMR, during the time periods that the restraints were in place, which indicated less restrictive interventions had been attempted and were ineffective. Additionally, there was no documentation in the EMR during these time periods, that the patient had attempted to get out of bed or attempted to remove a line. Nursing documentation for the same dates that restraints were in place included the following: 10/24 8:00 AM "no movement noted in any extremities. Pt is chemically sedated." 10/24 12:00 PM "Physical reassessment of all parameters...completed, and there are no changes from the previous documentation." 10/24 4:00 PM "Physical reassessment	4. **Documentation of the patient's response to the less restrictive measures.** 5. **Documentation of why restraints are discontinued.** 6. **Nurses are not to accept prn orders for restraints. The physician should be called to correct the order.** **Please see Appendix B, which is an example of the educational packets given to the trainers.** **Restraint documentation is audited daily via reports from the EMR and chart review. Appendix N is a copy of the restraint audit form.**		

	of all parameters....completed, and there are not changes from the previous documentation." 10/24 8:00 PM "Musculoskeletal: 0 movement, see neuro above...Neurosensory..Motor Control/Balance/Gait: 0 movement". 10/25 8:00 PM "does not move extremities to command or spontaneously." 10/26 4:00 AM "Physical reassessment of all parameters..completed, and there are no changes from the previous documentation." 10/26 8:00 AM "Motor Control/Balance/Gain: no movement noted. Musculoskeletal: no movement noted at this time, pt is chemically sedated." 10/26 12:00 PM "Physical reassessment of all parameters completed, and there are no changes from the previous documentation." 10/26 4:00 PM "Physical reassessment of all parameters...completed, and there are no changes from the previous documentation." 10/26 7:59 PM "Musculoskeletal: flicker of movement noted in UE's." There was no documentation that an assessment for the need of restraints, including the use of less restrictive measures and their effectiveness had been completed.			
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the hospital failed to ensure that physician's orders for restraints were not written for an as needed basis (PRN) for 1 of the 4 sampled patients (#44) who were restrained during hospitalization. The findings include: 1. The hospital's policy "Restraints and Seclusion", not dated, stated "III. Initiation of Restraint/Seclusion: D...orders for restraints or seclusion may not be written as a standing order on an as needed (PRN) basis. 2. A PRN order for restraints was written for 1 of 4 sampled	**As mentioned, our Restraint and Seclusion policy clearly prohibits the use of prn restraint orders. See Appendix A, Section *II*, E, 1. The specific physician who wrote this prn order was sent a letter by the Chief Quality and Safety Officer. Please see Appendix C attached. As mentioned above, education to nursing staff emphasized that prn orders are not acceptable and the nurse should contact the physician to clarify the order.**	**J. Robert Polk, MD VP, Chief Quality and Safety Officer**	**12/13/07**

	patients (#44) examples include: *Patient #44 was a 86 year old male who was admitted to the hospital on 9/30/07 with a diagnosis of left-sided subdural hematoma. He was discharged on 10/8/07. A physician order, dated 10/2/07, documented "may use soft restraints PRN for safety of patient." Nursing notes documented the use of various restraints on the patient from 10/2/07 through 10/7/07. On 11/08/07 at 11:45 AM, the Director of Patient Safety and 6 West Charge Nurse reviewed the patient's clinical record. They confirmed the record contained a physician's order for PRN restraints. Additionally, they confirmed the patient was in restraints from 10/2/07 through 10/7/07.			
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the hospital failed to ensure restraints were discontinued at the earliest possible time for 3 of 4 sampled patients (#'s 42,43, and 44), whose records were reviewed for restraint usage. The findings include: 1. The policy "Restraints and Seclusion", not dated, stated "IV. Assessment and Monitoring: B. Nurses assess for continued need for restraint at least every shift and as needed according to time-limited order expiration." This policy had not been followed. A specific assessment of the need to continue restraints was not defined by the implemented and maintained restraints. 2. Restraints were not discontinued at the earliest possible time for 3 of 4 sampled patients (#'s 42, 43, and 44). Examples included: *Patient #42 was a 90 year old female who was admitted to the hospital on 10/19/07 with diagnoses of urinary tract infection and Alzheimer's Disease. She was discharged on 10/22/07. An order	**As described above, the education for nursing staff emphasized the need for ongoing assessment of the need for restraints and removal when less restrictive measures are effective.**	**Aline Lee, Director of Patient Safety and Regulatory Compliance**	**Train-the-trainer sessions conducted on 12/12/07, 12/14/07, and 12/17/07. Unit education completed by 12/27/07.**

	on 10/19/07 at 2:00 PM stated the patient was unsafe to be out of bed and was attempting to get out of bed. A vest restraint was re-ordered on 10/21, 10/21, and 10/22/07. From 2:00 PM on 10/19/07, the patient remained restrained during her entire stay at the hospital. Nursing notes, at 8:00 PM on 10/19/07, stated the patient was restless and trying to get out of bed. At 4:00 AM on 10/20/07, the patient was noted to be sleeping in a chair. The patient continued to be sleeping in a chair. The patient continued to sleep and was hard to rouse until 8:00 PM on 10/21 when it was noted she was "Awake and alert. Follows commands." The patient was confused but no restlessness or behavioral problems were documented through 3:13 PM on 10/22/07 when she was discharged. Nursing notes chosen from a computerized list beginning throughout the patient's stay stated "Unsafe OOB" (unsafe out of bed) and "RemovLne" (remove line, referring to pulling at an IV or urinary catheter). The nursing notes did not describe unsafe behavior on the part of the patient. The reference to "RemovLne" was not valid as the patient had a vest restraint which would not prevent her from pulling at tubes or lines. The 6 West Charge Nurse, where the patient resided during her stay, was interviewed at 11:30 AM on 11/8/07. She reviewed the record and stated a specific reassessment of the need for restraints was not documented. *Patient #44 was an 86 year old male who was admitted to the hospital on 9/30/07 with a diagnosis of left-sided subdural hematoma. He was discharged from the hospital on 10/8/07. A verbal order for wrist and chest restraints, obtained on 10/2/07 at 11:30 AM, documented the patient was attempting to get out of bed and had cognitive impairment. On 10/4/07 (untimed) an order for vest, writs and ankle restraints documented the patient continued to attempt to get out of bed and was cognitively impaired. Additionally, contained in the record was an undated and untimed order for vest, wrist and ankle restraints with no documented reason for restraints. There was no documentation in the record for 10/2/07 that indicated the reason for the implementation of wrist restraints. On 10/3/07 at 4:00 AM it was documented that ankle restraints were used in addition to the vest and wrist restraints. Nursing notes, dated 10/3/07 at 6:50 AM,			

	documented the patient was "increasingly agitated, calmed with PRN pain meds and Haldol…" There was no documentation in the record for 10/3/07 that indicated the reason for the implementation of ankle restraints. On 10/3/07 at 4:00 PM, nursing notes documented the vest restraint was removed but that the wrist and ankle restraints were continued. There was no documentation I the record that indicated the condition of the patient had changed to warrant the removal of the vest restraint or continued use of the wrist and ankle restraints. On 10/4/07 at 8:00 AM, nursing notes documented the rest and ankle restraints were removed and that the vest restraint was reapplied. The vest restraint was discontinued on 10/7/07 8:00 AM. On 11/8/07 at 11:45 AM, the 6 West Charge Nurse and the Director of Patient Safety reviewed the record. They confirmed that a specific assessment of the continued need for restraints was not documented. *Patient #43 was a 72 year old male with a diagnosis of Stage III multiple myeloma. He was hospitalized for malnutrition and uncontrolled pain on 10/18/07 and expired on 10/27/07. On 10/23/07 he required intubation and was transferred to the ICU. On 10/24/07 at 2:00 AM bilateral wrist restraints were initiated for reasons, checked from a computer list of, UnsafeOOB (unsafe out of bed), ImpCogntn (impaired cognition) and RemovLne (removing a line). These remained in place through 10/25/07 at 12:00 AM. The same restraints were reinitiated on 10/25/07 at 9:00PM and continued through 10/26/07 at 8:00 PM. There were unsigned doctors orders for these restraints for the dates of 10/25 – 10/27/07. Nursing documentation for the same dates that restraints were in place included the following: -10/24 8:00 AM "no movement noted in any extremities, pt is chemically sedated." -10/24 12:00 PM "Physical reassessment of all parameters…completed, and there are no changes from the previous documentation." -10/24 4:00 PM "Physical reassessment of all	**The physician who was responsible for signing these orders was sent a letter from the Chief Quality and Safety Officer explaining the importance of signing daily orders for restraint. Please see Appendix D.**	**J. Robert Polk, MD VP, Chief Quality and Safety**	**12/14/07**

	parameters...completed, and there are no changes from the previous documentation." -10/24 8:00 PM "Musculoskeletal: 0 movement, see neuro above." "Neurosensory...Motor Control/Balance/Gait: 0 movement" -10/25/ 8:00 PM "Does not move extremities to command or spontaneously." -10/26/07 4:00 AM "Physical reassessment of all parameters...completed, and there are no changes from the previous documentation." -10/26 8:00 AM "Motor Control/Balance/Gait: 0 movement noted. Musculoskeletal: no movement noted at this time. Pt is chemically sedated." -10/26 12:00 PM "Physical reassessment of all parameters completed, and there are no changes from the previous documentation." -10/26 4:00 PM "Physical reassessment of all parameters...completed, and there are no changes from the previous documentation." -10/26 7:59PM "Musculoskeletal: flicker of movement noted in UE's." There was no documentation that the restraints were needed during the times they were in place and restraints were not discontinued at the earliest possible time.			
A 267	482.21(a)(2) QAPI Quality Indicators The hospital must measure, analyze, and ttack quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on review of clinical records, quality improvement documents, and staff interviews, it was determined the facility failed to ensure that performance improvement activities tracked and analyzed sufficient data necessary to adequately assess the hospital's services, operations, and processes of care related to patient's who experienced pressure ulcers. This finding includes:	**Saint Alphonsus tracks and monitors pressure ulcer data as recommended by the American Nurses Association's National Database of Nursing Quality Indicators (NDNQI) so that our data can be benchmarked against national data and within the Trinity Health System. Please see Appendix E, pages 65-74 for NDNQI data collection methods and data definitions.**		

	1. The CWOCN's activity sheets documented the CWOCN's had seen patients with pressure ulcers at the following monthly rates: 8/07: 22 patients with pressure ulcers. Of the 22 patients, 19 were identified as having hospital acquired pressure ulcers. 9/07: 17 patients with pressure ulcers. Of the 17 patients, 6 were identified as having hospital acquired pressure ulcers. 10/07: 31 patients with pressure ulcers. Of the 31 patients, 28 were identified as having hospital acquired pressure ulcers. The hospital's FY08 SARMC Quality and Safety Plan," dated 3/15/07, stated in the "Improve Pressure Ulcer Indicator" section that the hospital was "Improving definitions and data collection tools and processes for quarterly prevalence study. Defining standards of nursing assessment and pressure ulcer prevention interventions [sic]." The facility's quality improvement document was a "Pressure Ulcer Prevalence Report" dated 8/21/07. The report was a facility wide screening that documented whether or not the patients had a pressure ulcer. The report consisted of a grid. Each column of the grid was labeled with patient information (i.e. room number, name, age, sex, admit date, etc.) and information related to pressure ulcers (i.e. Braden score, types of pressure ulcer prevention in use, number of ulcers, etc.). Each row of the grid represented a separate patient. When asked bout the report on 11/16/07 at 9:45 AM, a CWOCN stated the report was completed one day each quarter, by completing a visual check of the patient and entering data on the grid which reflected each patient's status. The hospital's 8/21/07 "Prevalence Report" documented there were no less than 9 patients who had pressure ulcers. Of those 9 patients who had pressure ulcers, the "Prevalence Report" documented 6 patients had developed hospital acquired pressure ulcers, which included but were not limited to the following:	**The activity sheet data was not explained correctly to the surveyor and so the data quoted here is incorrect. The correct data is:** **8/07** **21 pressure ulcers/1387 discharges=1.5%** **8 hospital acquired/1387 discharges=0.6%** **9/07** **18 pressure ulcers/1354 discharges=1.3%** **5 hospital acquired/1354 discharges=0.4%** **10/07** **31 pressure ulcers/1428 discharges=2.2%** **14 hospital acquired/1428 discharges=1%** **These results are similar to the results found during our most recent (12/11/07) prevalence study which found:** **Prevalence: 2 pressure ulcers/185 patients=1.1%** **Incidence: 0 pressure ulcers developed within 3 days** **Please see Appendix F for prevalence results as compared to the previous quarter. Please also see Appendix G for data comparing SARMC with Trinity Health System. Please note that SARMC is within the target range (green). The target is based on national**		

	a. The row for Patient #24 on the 8/21/07 "Prevalence Report" stated the following: The first 6 columns documented his room number, name, MRN, age, sex, and admission date. The 7th column stated "Assessment Prior to Survey." A "yes" was placed in the box. The 8th column stated "Braden Score." A "17" was placed in the box. The 9th column stated "Time Since Last Assessment." The box stated ">12 – 24 Hours." The 10th column stated "Pt (patient) at Risk." The box stated "Yes." The 11th column stated "Pressure Ulcer Prevention" and was subdivided into 3 columns labeled "Yes", "No Evidence", and "Not Applicable." A check mark was placed in the "No Evidence" box. The 12th column stated "Type of Pressure Ulcer Prevention in Use" and was subdivided into 4 columns labeled "Pressure Reducing Surface", "Repositioning", "Nutritional Support", and "Other". A check mark was placed in the column marked "Nutritional Support". The 13th column stated "Number of Ulcers" and was subdivided into 3 columns labeled "Total", "Hospital Acquired", and "Unit Acquired". A "1" was placed in the "Total" column and the "Unit Acquired" column. The 14th column stated "Number of Ulcers at Each Stage" and was subdivided into 5 columns labeled "Stage I", "Stage II", "Stage III", "Stage IV", and "Unstageable". A "1" was placed in the "Stage II" column. The 15th column stated "Ulcer Location(s) (Use Loc. Nbr. On	**data from NDNQI.** **The quarterly prevalence study, conducted as required to participate in NDNQI, is used for ongoing PI monitoring. The data has been analyzed and actions implemented as a result. For example, in response to prevalence study data which revealed a pattern of ear redness due to oxygen tubing, tubing padding was implemented in Fall 2006 and resulted in a reduction in findings of ear skin breakdown. The prevalence studies have also resulted in identification of the following issues and improvement actions:** **1. Identified that nursing staff needed more education to differentiate between skin redness due to pressure vs. excoriation and other causes of redness. In response, education on skin assessment and care was added to new hire orientation, CWOCNs began participating in unit-based ongoing clinical education, and training for prevalence study participants was standardized. In addition, all areas of redness identified during a prevalence study are assessed by the CWOCN to**		

	figure)." The word "buttock" was placed in the box. The 16th column stated "Patient on O2 (oxygen)" and was subdivided into 2 columns labeled "Yes", "No", and "NA". A checkmark was placed in the box under the "No" column. The 18th column stated "Reason Patient Not Assessed" and was subdivided into 4 columns labeled "Not Available", "Patient Discharged", "Patient Refused", and "Contraindicated". The boxes were left blank for Patient #24. In summary, the "Prevalence Report" documented Patient #24 was at risk and had developed a unit acquired, Stage II pressure ulcer on his buttocks. However, there was "No Evidence" of "Pressure Ulcer Prevention" measures being used beyond nutritional support. Additionally, the "Integumentary/Skin" section of Patient #24's nursing notes documented "Reddened Skin...Buttocks...skin is red, blanches, barrier cream applied, instructed pt (patient) to turn to his side as much as possible." The documentation was dated 8/9/07 at 8:00 AM, 11 days prior to the "Prevalence Report." Similar information related to the area was documented in his nursing notes dated 8/12/07, 8/13/07, 8/14/07, 8/15/07, and 8/21/07. His record also documented on 8/21/07 at 3:30 PM an air bed was initiated, per suggestion of the 8/21/07 prevalence study. The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, was not sufficient to ensure Patient #24 received timely and appropriate preventative care related to this skin integrity. The study did not document patient specific day to day data to identify specific quality indicators (i.e., the review and assessment of Patient #24's care record for compliance of repositioning, implementation and adherence to the hospital's wound and Braden scale policies and other such operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). b. The 8/21/07 "Prevalence Report" included a row for Patient	**confirm that it is caused by pressure.** **2. Identified that head-to-toe skin assessments were not consistently documented on admission and therefore, the hospital acquired rate was inflated because there was no documentation of the pressure ulcer being present on admission. As a result, we have revised the policy to clearly define that a head-to-toe skin assessment and Braden risk assessment will be performed and documented on admission and daily. The EMR and paper documentation forms have been revised to facilitate this.**		

	#25. In summary, the "Prevalence Report" documented Patient #25 was at risk and had developed a hospital acquired Unstageable pressure ulcer on his head. The report documented there was "No Evidence" of "Pressure Ulcer Prevention" measures being used. However, Patient #25's nursing notes dated 8/9/07 at 8:00 AM documented he had developed a "1x2 cm purple pressure score" on his left buttocks and a "1x4 purple pressure sore" on his right posterior upper thigh. The notes documented that a rotation mattress was initiated on 8/9/07 at 11:00 AM. Similar information related to the pressure areas on Patient #25's thigh and buttocks was documented in his nursing notes dated 8/10/07, 8/12/07. and 8/13/07. The nursing notes on 8/13/07 at 8:00 PM also documented he had developed skin breakdown on the back of his head. The notes stated "Area reddish purple colored approx size of quarter, Pt (patient) using head doughnut." Similar information regarding the pressure areas on his thigh, buttocks, and head was documented in his nursing notes dated 8/14/07, 8/15/07, 8/16/07, and 8/17/07. The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospitals [performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to the review and assessment of the patient's care record for compliance of repositioning, the implementation and adherence of the hospital's wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). c. Patient #33's 8/11/07 nursing assessment stated "Skin Breakdown...Bottom...Protective Ointment Applied." Similar information regarding the area was documented daily in his nursing assessments dated from 8/12/07 to 8/21/07. However, the 8/21/07 "Prevalence Report" included a row for	**As mentioned above, the quarterly prevalence study, conducted as required to participate in NDNQI, is used for ongoing PI monitoring. It is not the purpose of the prevalence study to identify on a daily basis patients who have, or are at risk for, pressure ulcers. The CWOCNs receive a daily report of patients with documentation in the EMR of selected types of skin breakdown. They also receive a report of patients with low Braden scores. These lists, along with referrals from nurses and physicians, are used to create the CWOCNs' daily work lists.** **SARMC has revised the Pressure Ulcer PI Plan to include the aim, goal, measures, actions, team membership and reporting structure. Please refer to Appendix H. Measures include:** 1. Pressure ulcer prevalence as measured by quarterly NDNQI prevalence study. 2. Percentage of patients with hospital acquired	**Aline Lee, Director of Patient Safety and Regulatory Compliance**	**12/18/07**

	Patient #33 but information related to his pressure ulcers was not included on the grid. Column 18 stated "Reason Patient Not Assessed" and an "X" was placed in the sub-column for "Contraindicated" an employee who worked in the PI department stated they did don't know why he was contraindicated. The facility's "Pressure Ulcer Prevalence report," completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospitals performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to: the review and assessment of the patients care record for compliance of repositioning, the implementation and adherence of the hospitals wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). d. The 8/21/07 "Prevalence Report" included a row for Patient #23. In summary, the "Prevalence Report" documented Patient #23 was at risk and had developed a hospital and unit acquired pressure ulcer. The report documented she had developed a Stage I and Stage II pressure ulcer and that there was "No Evidence" of "Pressure Ulcer Prevention" measures being used. Further, summary documentation of the 8/21/07 "Prevalence Study" documented a Stage 1 hospital acquired pressure ulcer on her spine. However, the summary did not include documentation of the pressure area on her sacral area. The summary information was not consistent with the "Prevalence Report." Additionally, Patient #23's nursing notes dated 8/16/07 at 1:00 PM documented she had developed "Skin Breakdown...sacrum...small open area 1"x1/4 in w/surrounding redness. Cream applied." Similar information related to the pressure area on 8/17/07, 8/18/07, 8/19/07, 8/20/07, and 8/21/07. The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, did not provide sufficient information necessary	Pressure Ulcers by Stage. 3. Percentage of patients with skin assessment and Braden scale documented within 24 hours of admission. 4. Percentage of patients with skin assessment and Braden scale documented daily. 5. Percentage of patients with documented interventions based on Braden subscale. 6. Incidence of hospital-acquired pressure ulcers **These measures are consistent with the recommendations of the Institute for Healthcare Improvement's 5 Million Lives Campaign.** **The following changes have been made in our data collection process in order to obtain these measures:** **A daily report is sent to PI which lists each patient and includes:** • **documented head to toe skin assessment**	**Aline Lee, Director of Patient Safety and Regulatory**	**12/21/07**

	to adequately assess the hospital's performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to: the review and assessment of the patients care record for compliance of repositioning, the implementation and adherence of the hospitals wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). On 11/19 at 2:30 PM, a hospital employee who worked in the PI department stated the hospital did retain a day to day cumulative data base of patients that developed pressure ulcers. She confirmed the PI department did not have a data base of reviewed hospital services and operations aspects of performance that could have been used to assess the process of care and could have lead to the reduction of the development of pressure ulcers. She said the hospital's PI department did not have a written plan based on cumulative data to reduce the rate of hospital acquired pressure ulcers. The Prevalence study did not lead to documented evidence that the hospital had followed their 3/15/07 "FY08 SARMC Quality and Safety Plan," (on improving their "definitions and data collection tools and processes for quarterly prevalence study" or had defined "standards of nursing assessment and pressure ulcer prevention interventions") and the study was not used in a development of a written plan to reduce the rate of hospital acquired pressure ulcers. Further, the Prevalence study did not document patient specific day to day data to identify patient specific quality indicators (i.e., review and assessment of the patients care record for compliance of repositioning, implementation and adherence to the hospital's wound and Braden scale policies, and other such operational aspects of performance that could have lead to the development of the pressure ulcers). The facility failed to ensure the pressure ulcer quality improvement system included sufficient information necessary to adequately assess the hospital's services, operations, and the processes of care	**and Braden risk assessment within 24 hours of admission by unit** • **documented head to toe skin assessment and Braden risk assessment within the last 24 hours** • **Braden score for each subscale and total** • **Interventions documented** • **Skin breakdown documented** • **Whether or not CWOCN saw the patient** **This data will be compiled on a monthly basis and analyzed by the Pressure Ulcer Subcommittee of the Nursing Quality Outcomes Council. Improvement actions will be implemented based on the data results.** **We began measuring incidence of hospital acquired pressure ulcers with the December 2007 quarterly prevalence study. As recommended by NDNQI, incidence of hospital acquired pressure ulcers are measured by reassessing all patients included in the prevalence study who are still in the hospital 3 days later. The 3**	**Compliance** **CWOCNs**	**12/11/07**

	related to patients' skin integrity. 2. Patient #33 was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. An incident report, dated 8/23/07, documented that on 8/22/07, the "PT (patient) with 3/4 in X 1/4 in oval skin breakdown on L (left) coccyx area, purple discoloration, and several blisters or R (right) coccyx on 8/22, skin protectant (sic) cream applied and pt (patient) repositioned on sides. Wound consult ordered. On 8/23 blisters no longer intact and 1in round and 1/4in round state I skin breakdown present. Wound nurse in to evaluate. Skin protectant (sic) cream placed w/saran wrap to prevent rubbing off." An investigation related to the incident report could not be found. When asked, on 11/8/07 at 9:10 AM, an RN who was the unit manager at the time the patient had developed the pressure ulcer, stated she did not investigate the incident report. On 11/8/07 at 9:30 AM, the DNS stated that incident reports are first given to the unit manager to investigate and then passed on to the PI department to analyze the information and identify reoccurring issues. He said that to the best of his knowledge, the above incident was not investigated. On 11/9/07 at 2:30 PM, 2 hospital employees who worked in the PI department stated they were unaware of the incident report and confirmed the report was not used to assess the hospital's process of patient care to reduce the frequency of hospital acquired pressure ulcers. The facility failed to ensure all pertinent incident information was investigated and analyzed in an effort to identify and safeguard against reoccurring issues.	**day time frame is based on the average LOS.** **Incident reports related to skin breakdown will be sent to the Performance Improvement Coordinator who facilitates the Pressure Ulcer Team for analysis of patterns/trends and opportunities for improvement.**	**Lori Sweet, RN, Risk Management**	**12/27/07**
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.	**Please see response to A 395.**		

	The CONDITION is not met as evidence by: Based on review of hospital policies, record review, and staff interviews, it was determined the hospital failed to ensure Supervising Registered Nurses provided adequate oversight and evaluation of patient care. This failure resulted in a lack of appropriate care being provided to patients in the treatment and prevention of pressure ulcers. The findings include: 1. Refer to A395 as it relates to the facility's failure to ensure registered nurses provided supervision and evaluation of patient care necessary to prevent and treat pressure sores consistent with current standards of nursing practice and hospital policies and procedures.			
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. The STANDARD is not met as evidenced by: Based on review of hospital policies, record review, and staff interviews, it was determined the hospital failed to ensure registered nurses provided supervision and evaluation of patient care necessary to prevent and treat pressure sores consistent with current standards of nursing practice and hospital policies and procedures. This failure resulted in 8 of 18 patients (3's 23, 24, 25, 33, 46, 56, 57, and 59) whose records were reviewed and had documented pressure sores, not receiving adequate care in the prevention and treatment of pressure sores. The findings include: 1. The hospital's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE: CULTURE, IRRIGAITON AND DEBRIDEMENT" policy, revised 5/06, stated in the "Definition of and Treatment for Pressure Ulcers" section of the policy stated the following: Stage I – "The ulcer appears as defined area of persistent redness in	**The following actions have been taken in response to these finding:** **1. The Braden Scale and Skin Assessment policy (See Appendix I) has been revised to include:** **a. A head-to-toe skin assessment within 24 hours of inpatient admission** **b. A Braden risk assessment within 24 hours of admission** **c. Head-to-toe skin assessment and Braden risk assessment daily** **d. Addition of a section on Pediatric**	**Aline Lee, Director of Patient Safety and Regulatory Compliance**	**12/27/07**

	light pigmented skin, where as in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues." Suggested care and treatment of stage 1 pressure ulcers was to use moisturizing creams or protective ointment to affected areas. Stage II – "Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater…It is shallow, moist, painful, and pink-red in color and may have superficial yellow slough.." The care an treatment for stage 2 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressing every 24 – 48 hours. Stage III – "Full thickness skin loss involving damage to, or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining adjacent tissue." The care and treatment for stage 3 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, loosely pack the wound with gauze and wound gel or saline and change the dressings every 24-48 hours. Stage IV - "Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon or joint capsule)…" The care and treatment for stage 4 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, loosely pack the wound with gauze and wound gel or saline and change the dressings every 24 hours. Non-stageable - "When necrotic tissue is present, a pressure ulcer cannot be accurately staged until the necrotic tissue is removed. Dark purple or bruised areas, over bony prominences, with intact skin may indicate deeper tissue damage." The "Documentation" section of the policy stated staff were to "Document daily and prn the size, color, character, exudate of all	**Considerations with addition of the Modified Braden Q assessment scale for patients 5 years and younger (except neonates)** **e. Consult with CWOCN for "pre-existing, suspected, and/or newly developed areas of pressure, as needed."** **2. The Wound and Pressure Ulcer—Assessment and Care; Culture, Irrigation, and Debridement policy (Appendix J) has been revised to update the table that describes various products and wound care techniques and their indications.** **3. The nursing admission assessment form has been revised to allow documentation of the 6 Braden subscales rather than just the total score. (See Appendix K, page 4 of 6) The Braden Scale has been added as a**		

	wounds. The policy further stated "The Braden Scale is a rating scale that will be used by (hospital's name) staff to assess for pressure ulcer risk at admission and daily." The "BRADEN SCALE for Predicting Ulcer Risk" policy revised in 9/06, and again in 11/07, stated "The Braden Scale for predicting Pressure Sore Risk is a tool that allows nurses and other health care providers to score a patient's level for developing pressure ulcers. Patients are assessed for pressure ulcer risk at admission and daily." Some recommended interventions included the following: Low Risk Score 15-18: Encourage patient to turn and shift position Address risk factors. Moderate Risk Score 13-14: Supplement turning with small shifts in position. One example was to increase turning with a 30 degree foam wedge or pillows. Provide appropriate pressure reducing support surface. Certified Wound-Ostomy-Continence Nurse consult. High Risk Score 10-12: Supplement turning with small shifts in position. Provide appropriate pressure reducing support surface. Certified Wound-Ostomy-Continence Nurse consult. Severe Risk Score less than or equal to 9: Supplement turning with small shifts in position. Provide appropriate pressure reducing support surface. Certified Wound-Ostomy-Continence Nurse consult.	**reference to the form. (See Appendix K, page 6 of 6)** **4. The electronic medical record (EMR) has been revised to:** **a. Include a prompt (in red) to perform head-to-toe skin assessment on admission and daily** **b. Organize the intervention pick list by Braden sub-scale.**		

	The frequency of patient positioning was not addressed in either the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" or the "BRADEN SCALE for Presdicting Ulcer Risk" policies. When asked about patient positioning, staff stated the following: On 11/9/07 at 10:40 AM, a CWOCN confirmed the above policy and procedure and stated it was the hospital's best practice to turn patients at least every 2 hours. On 11/5/07 at 1:53 PM, a nurse, who was a unit manager, stated patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning. The nurse stated that all patients' positions were to be documented every 2 hours in the EMTEK whether they could self turn or needed assistance with turning. On 11/5/07 at 2:16 PM, a nurse, who worked at the hospital, stated all patients were to be repositioned every 2 hours if they cannot move or need assistance with repositioning. The nurse also stated that CWOCNs were to be consulted for all patients that had developed or had pressure ulcers prior to their admission. The nurse stated that patients' positioning was to be documented in the EMTEK.	**The frequency of patient positioning is addressed in the Braden Scale and Skin Assessment policy (Appendix I, page 2 of 8) as an intervention when patients have a deficit in the Braden Sensory or Mobility/Activity subscales.** **Education for staff regarding pressure ulcer prevention was accomplished through a train-the-trainer approach. Trainers were identified for each unit. The unit trainers attended one of three sessions conducted by the clinical educators. At these sessions, the trainers received packets containing flyers, revised policies, a summary of the changes to the electronic medical record (EMR) or paper forms, and talking points for use at staff meetings, in-services, posters, bulletin boards, or other forms of communication. Education focused on the following key points:** **1. Head to toe skin assessment and pressure ulcer risk assessment on**	**Aline Lee, Director of Patient Safety and Regulatory Compliance**	**Train-the-trainer sessions conducted on 12/12/07, 12/14/07, and 12/17/07. Unit education completed by 12/27/07.**

	On 11/5/07 at 2:16 PM, a second nurse, who worked as unit manager, stated all patients were to be repositioned every 2 hours if they could not move or need assistance with repositioning. The nurse also stated CWOCNs were consulted for all patients that had developed or had pressure ulcers prior to admission. The nurse stated that patients' positioning was documented in the EMTEK whether they could self turn or needed assistance with turning. On 11/5/07 at 2:39 PM, a nurse who worked at the hospital stated, all patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning. On 11/5/07 at 3:30 PM, the hospital's DNS stated all patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning. On 11/6/07 at 9:32 AM, a CWOCN stated all patients that were identified as having a Braden scale score of 13 or less or had pressure ulcers were to be followed by a CWOCN. She stated they were responsible for assessing each patient to identify the patient's individual special needs to help prevent the development or further development of pressure ulcers including obtaining appropriate pressure reducing support surfaces, wound treatment, and staff education. On 11/8/07 at 10:46 AM, a nurse who worked at the hospital stated that patients were to be turned every 2 hours or more if needed. The nurse stated they rotated patients from lying on their right side, to their back, then to their left side. She stated this was recorded in the "ACTIVITY Position" section of the patient's EMTEK.	**admission and daily** **2. Documentation of skin assessment, pressure ulcer prevention measures, and pressure ulcer treatment.** **3. Use of modified Braden Q scale for assessment of patients age 5 and under (except neonates)** **4. Pressure ulcer prevention interventions based on Braden subscales scores rather than overall score** **5. Referral to CWOCN.** **Please see Appendix L, which is an example of the educational packets given to the trainers.** **To reinforce the unit-based training, daily rounds are being made on units to provide one-to-one coaching and evaluation of skin assessment, risk assessment, prevention measures, and documentation. An audit/teaching tool has been developed to standardize the rounding process. Please see Appendix M.**		

	The facility failed to ensure patients were assisted to reposition every 2 hours and that the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION and DEBRIDEMENT" and the "BRADEN SCALE for Predicting Ulcer Risk" policy were consistently implemented as follows: Patient #33 was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. The patient was a 66 year old male that was admitted to the hospital after being found unresponsive in his home. The patient's Braden scale on 8/13/07 was 9 (severe risk: supplement turning with small shifts in position, provide appropriate pressure reducing support surface, Certified Wound-Ostomy-Continence Nurse consult). Patient #33's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 9. Additionally, the "ACTIVITY Position" section of his EMTEK documented that he had not been repositioned every 2 hours or provided supplemental turning with small shifts in position during the following dates and times: 8/11/07: right side from 10:00 PM to 2:00 AM on 8/12/07. His nursing assessment stated "Skin Breakdown...Bottom...Protective Ointment Applied.			

	8/12/07: left side from 2:00 AM until 10:00 AM, supine from 10:00 AM to 2:00 PM and supine from 6:00 PM to 12 midnight. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM, 12:00 PM, 6:00 PM and 8:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...Skin is reddened." His treatment flow sheet listed his Braden score as 11. 8/13/07: left side from 12 midnight to 4:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...Buttocks are reddened, no skin breakdown noted." His treatment flow sheet listed his Braden score as 9. 8/14/07: right side from 12:00 AM to 4:00 AM, supine from 4:00 AM to 2:00 PM and on his right side from 2:00 PM to 6:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...Reddened." His treatment flow sheet listed his Braden score as 11. 8/15/07: right side from 4:00 AM to 12:00 PM. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc) had occurred at 8:00 AM and 10:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...redness noted skin intact." His treatment flow sheet listed his Braden score as 10. 8/16/07: right side from 12:00 AM to 8:00 AM and supine from 6:00 PM to 4:00 AM on 8/17/07. His nursing assessment stated "Skin Breakdown...Bottom...No dressing." His treatment flow sheet listed his Braden score as 11.			

	8/17/07: supine 6:00 AM to 10:00 AM and supine from 10:00 PM to 8:00 AM on 8/18/07. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM. His 8/17/07 nursing assessment stated "Skin Breakdown...Bottom...less reddened than previous day, no open areas noted." His 8/18/07 nursing assessment stated "Skin Breakdown...Bottom...No dressing. 6-in diameter of redness. Open bleeding area noted." His treatment flow sheet listed his Braden score as 17 on 8/17/07 and as 11 on 8/18/07. The facility failed to ensure Patient #33 was appropriately reposition every 2 hours, that the Braden scale policy interventions were implemented given his continued low scores (supplement turning with small shifts in position, provide appropriate pressure reducing support surface, certified Wound-Ostomy-Continence Nurse consult) and that appropriate wound care occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24 - 48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT AND CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy.			

	Patient #33's medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the progression of his pressure ulcer. The "ACTIVITY Position" section of his EMR documented that he was not positioned appropriately during the following dates and times: 8/19/07: right side from 4:00 AM to 10:00 AM, supine from 10:00 AM to 10:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...No dressing, open area on R buttocks. Reddened around and on L..." His treatment flow sheet listed his Braden score as 9. 8/20/07: supine from 2:00 PM to 8:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...reddened, has two small areas that are open and occasionally bleeding, cleaned well, applied barrier cream." His treatment flow sheet listed his Braden scores as 11 and 9. 8/21/07: His nursing assessment stated "Skin Breakdown...Bottom...reddened, coccyx, has small opening noted to right buttocks, cleaned well and applied barrier cream..." Additionally, a CWOCN consult, dated 8/21/07, stated "First step mattress obtained fro comfort care." His treatment flow sheet listed his Braden score as 11 and 13.			

	8/22/07: His nursing assessment stated "Skin Breakdown...Bottom...1 in blister and purple discoloration. 3/4in oval state 1 breakdown." Additionally, an 8/23/07, the "patient with 3/4 in x 1/4 in oval skin breakdown on L coccyx area, purple discoloration, and several blisters on R coccyx on 8/22, skin protectant cream applied and pt repositioned on sides. Wound consult ordered. On 8/23 blisters no longer intact and 1in round and 1/4in round stae I skin breakdown present. Wound nurse in to evaluate. Skin protectant cream placed w/saran wrap to prevent rubbing off." A Braden score was not documented on his treatment flow sheet.			

	8/23/07: left side from 2:00 AM to 8:00 AM. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 4:00 AM. His nursing assessment stated "Skin Breakdown…Rectum…1.5cmx2cm…No dressing Partial thickness skin loss blistered excoriated 1.5cmx2cm. Barrier cream applied...Bottom...No dressing wound is excoriated inflamed large listers have opened and drained...Rectum...3cmx3cm...No dressing Partial thickness skin loss open blister 3cmx3cm. Barrier cream applied." Additionally, a CWOCN consult, dated 8/23/07, stated "Was not informed on 8/21 that this patient had skin breakdown related to being down at home. Has skin breakdown of both buttocks related to being down at home - now outer skin has sloughed and red wound base is seen. Skin protective paste is being applied qid. Left heel has black eschar - dry - no drainage - probably related to how he was laying on the floor at home. Orders written to paint the area with betadine bid and wear prevalon boots at all times." His treatment flow sheet listed his Braden score as 18.			

	The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours and that appropriate wound care occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24-48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, a CWOCN was not contacted until 8/21/07 despite his low Braden scores (prior to the 8/23/07 score of 18) and having an open wound since 8/18/07. On 11/9/07 at 10:10 AM, a CWOCN confirmed the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer, per policy, until 8/21/07. His medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the CWOCN nurse consult and the continuation of open areas on his buttocks. The "ACTIVITY Position" section of his EMTEK documented that he was not positioned appropriately during the following dates and times:			

	8/24/07: His nursing assessment at 12:00 AM stated "Contusion/Hematoma...R Heel...4CMx2CM...Hematoma black no open skin noted bootie and barrier cream applied." His nursing assessment at 8:00 AM stated "Skin Breakdown...Bottom...Skin Breakdown...Rectum...3cmx3cm...Unchanged from documentation, cream applied and plastic wrap...Skin Breakdown...Rectum...1.5cmx2cm...Unchanged from documentation...Contusion/Hematoma...R...Heel...4CMx2CM..." His treatment flow sheet listed his Braden score as 16. 8/25/07: His nursing assessment stated the areas on his rectum continued to be open and barrier cream and plastic wrap were being used. He also had a reddened area on his buttocks that was also being treated with barrier cream and plastic wrap.. His PT notes stated he was also using Sage boots and an air mattress. His treatment flow sheet listed his Braden score a 13. 8/26/07: His nursing assessment stated "Dressing moist reinforced" and the shift summary report stated, "The areas on his bottom are very irritated from the loose stools and bleed slightly during cleaning of them..." His treatment flow sheet listed his Braden score as 10. On 11/7/07 at 1:53 PM, an RN, who was a unit manager on the unit to which the patient was admitted, stated nursing attempted to reposition the patient but he always went back to lying on his back. She also stated the patient was incontinent of stool and urine and was often moist or wet.			

	On 11/5/07 at 2:16 PM, a second nurse, who worked as unit manager on the unit to which the patient was admitted, stated the patient was not able to lay on his sides because it affected his vital signs and his blood pressure would drop and this was why he was not repositioned. 8/27/07: supine from 6:00 AM to 2:00 PM. His record documented that his linens had been changed at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 10:10 AM. His nursing assessment stated "Skin Breakdown...Bottom...reddened excoriated bottom and coccyx. Barrier paste and saran wrap applied...Skin Breakdown...Rectum...3cmx3cm...reddened and excoriated barrier paste and saran wrap applied...Skin Breakdown...Rectum...1.5cmx2cm...reddened and excoriated barrier paste and saran wrap applied." His treatment flow sheet listed his Braden score a 11. 8/28/07: supine from 8:00 AM to 12:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 10:00 AM. His nursing assessment at 8:15 AM stated "Skin Breakdown...Bottom...Barrier cream with saran wrap, all the wounds are in a butterfly shape all connected together into one wound now...Contusion/Hematoma...R Heel...4cmx2cm..." His nursing assessment at 10:00 PM stated "Skin Breakdown...Bottom...Pt with State II decubitus ulcer on sacral region. Saran Wrap dressing intact. No oozing noted..."			

	Additionally, a CWOCN consult, dated 8/28/07 at 11:30 am, stated "coccyx remains with dark eschar over it open area scattered around on the soft tissue will continue with treatment of protective paste and plastic wrap spoke with nursing and emphasized with nursing importance of turning - right heel plantar posterior was black - soft appears to be resolving blood blister - will continue with betadine to area and prevelon boots..." His treatment flow sheet listed his Braden score as 9, 11, and 15. On 11/9/07 at 10:10 AM a CWOCN confirmed the above documentation and stated it was the hospital's best practice to run patients at least every 2 hours. She also confirmed that if a patient's Braden scale was 9 or less, that nursing staff, per policy, should be supplementing turning with small shifts in the patient's position. The facility failed to ensure Patient #33 was appropriately reposition every 2 hours and there was no documented evidence of supplemental turning with small shifts in position, despite the ongoing progression of his pressure ulcers. Additionally, despite the CWOCN's emphasis on the "importance of turning" the "Activity Position" section of his EMTEK continued to document he was not repositioned every 2 hours during the following dates and times:			

	8/29/07: right side from 2:00 PM to 6:00 PM and then supine until 10:00 PM. His record also documented he had a pad change at 2:00 PM. His nursing assessment at 12:41 AM stated "Skin Breakdown...Bottom...ointment applied, stage 2-3 ulcer bilaterally..." His nursing assessment at 3:30 PM stated "Skin Breakdown...Bottom...reddened to bilateral buttocks, left buttocks has much larger area with redness to outside and some blackness to center of wound, very scanty amount of bleeding occasionally. Repositioning frequently..." His treatment flow sheet listed his Braden score as 15. 8/30/07: His record also documented he had received a back rub at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 9:45 AM. His nursing assessment stated "Skin Breakdown...Bottom...Area showing signs of healing. No s/s of infection noted. Area cleansed with peri-wipe, barrier cream applied and covered with plastic wrap...Contusion/Hematoma...R heel...4cmx2cm...Skin remains intact..." His treatment flow sheet listed his Braden score as 12.			

	8/31/07: left side from 6:00 AM to 10:00 AM, on his right side from 10:00 AM to 2:00 PM, and on his right side again from 10:00 PM until 4:00 AM on 9/1/07. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 12:00 PM and that he received a backrub, barrier cream and his linen was changed at 2:00 AM. Additionally, a CWOCN consult, dated 8/31/07 at 3:30 PM, stated "area of dark eschar is getting smaller - red wound visible around perimeter of wound will continue with current treatment plan of skin protective paste and saran wrap..." His treatment flow sheet listed his Braden score as 15. 9/1/07: His nursing assessment stated "For wound care see treatment Flow sheet..." and his heel was floated in AFO boots. However, his treatment flow sheets did not include documentation of his wounds until 9/12/07. His treatment flow sheet listed his Braden score as 14 and 16. The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours and that his records consistently reflected his wound status and interventions. Additionally, the "ACTIVITY Position" section of his EMTEK documented he continued to not be repositioned appropriately during the following dates and times:			

	9/2/07: right side from 2:00 PM to 6:00 PM and supine from 6:00 PM to 10:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 4:00 PM and 8:00 PM and that his bed pad was also changed at 8:00 PM. His nursing assessment stated "Coccyx area is notable for full thickness skin breakdown with pink granular tissue, old tissue is black. Area is moist, without sys of infection, covered with transparent dressing...R heel...4cmx2cm...intact skin has 2x3 cm area with black color. Without drainage or dressing..." His treatment flow sheet listed his Braden score as 15. 9/3/07: His nursing assessment stated "Bottom…large decubitus noted w/black eschar…R heel…4cmx2cm…r heel has eschar…" His treatment flow sheet listed his Braden score as 14 and 19. 9/4/07: right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 1:30 PM. His nursing assessment stated "Bottom…left decubitis with brownish tissue, reddened and open on both cheeks, wound care done with saran wrap replaced…" His nursing assessment at 4:00 PM stated "…Bottom…bilateral ulcerations on buttocks dressing in place blackened areas noted wound service following…R (right) heel…4CMx2CM…heels remain off bed et boots in place (sic) and no pressure is on feet or heels..." His treatment flow sheet listed his Braden score as 13 and 12.			

	9/5/07: left side from 6:00 AM to 6:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 11:54 AM and the Occupational Therapist had assisted Patient #33 to shave and comb his hair at 2:00 PM. His nursing assessment stated "Bottom...5cm in diameter blacken circular area with superficial breakdown peripherally...R (right) heel...4CMx2CM...blackened area intact..." His treatment flow sheet listed his Braden Score as 13. 9/6/07: His nursing assessment stated "Bottom...Barrier cream placed per wound care nurse. Black eschar over 2 inch diam (diameter) area...R (right) heel...4CMx2CM...black, 1/2 inch diam. Prevalon boot intact..." His treatment flow sheet listed his Braden score as 16 and 12. 9/7/07: His nursing assessment stated "Bottom...Sacral area with area of eschar. Some slight bleeding around edges while cleaning him up. Area of coccyx appears to be healing. Area is pink with granulation...R (right) heel...4CMx2CM...Not observed..." Additionally, the CWOCN's noted, dated 9/7/07 at 4:50 PM stated "...staff instructed on wound care as he just moved to this unit..." His treatment flow sheet listed his Braden score as 17, 16, and 10.			

	9/8/07: His nursing assessment stated "Bottom…Pt has very large full thickness breakdown on buttock. 2 areas on the L (left) buttock and 1 on the R. (right) Largest area has necrotic tissue in the center with bleeding granulation tissue surrounding. Cleansed with sterile saline and applied polymen dressing. Other breakdown on the R (right) is smaller but (sic) still full thickness decub with granulation tissue present. MD notified...R (right) heel...4CMx2CM...has dark purple (sic) blood blister on the R (right) heel, skin is intact and dry..." His treatment flow sheet listed his Braden score as 12 and 10. 9/9/07: supine from 6:00 PM to midnight. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 PM and 10:00 PM. His nursing assessment at 8:00 AM stated "Skin Breakdown…Bottom…Dressing with small amount of dried drainage; changed and new polymen applied. Patient has full-thickness breakdown on buttocks; two areas on l (left) and one on R (Right). The left buttock has black necrotic tissue in center and bleeding granulation tissue surrounding. The right is full-thickness decub with granulation tissue...Contusion/Hematoma...R (Right) Heel...4cmx2cm...blood blister to R (right) heel." Additionally, his nursing assessment at 8:00 PM stated "Reddened Skin...Nose...(checked) Dressing, clean, dry, intact..." His treatment flow sheet listed his Braden score as 11 and 12.			

	9/10/07: right side from 4:00 AM to 9:00 AM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM. His nursing assessment stated at 8:00 PM "Skin Breakdown...Bottom...Minimal drainage, no dressing present. Large eschar present with reddened and open skin surrounding it. No s/s (signs/symptoms) of infection...Reddened Skin...Nose...Skin reddened. Dressing clean, dry, and intact. No s/s (signs/symptoms) of infection." A Braden score was not listed on his treatment flow sheet. 9/11/07: left side from 12:00 PM to 12:00 PM on 9/12/07. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc) had occurred at 2:00 PM on 9/11/07 and 8:00 AM and 10:00 AM (during a bed bath) on 9/12/07. His nursing assessment stated "Skin Breakdown...Bottom...reddened open area to coccyx, small area of escar (sic) noted to center of wound...Contusion/Hematoma...R (right) heel...4cmx2cm...pt (patient) also has a very small blister noted to left heel...Reddened Skin...Nose...reddened, very small area that has been open but is healing." His treatment flow sheet listed his Braden score as 14 and 12.			

	9/12/07: right side from 12:00 PM to 6:00 PM. His record also documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:08 PM. His nursing assessment stated "Skin Breakdown...Bottom...no dressing, skin barrier applied per wound care orders. Reddened Skin...Nose... (checked). Dressing clean, dry, intact..." His treatment flow sheet listed his Braden score as 15 and 12. 9/13/07: left side from 12:00 AM to 4:00 AM, supine from 4:00 Am to 2:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 10:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...No drsg. (dressing) area is red and has so (sic) eschar that is dry. Ointment applied...Confusion/Hematoma...R (right) heel...4cmx2cm...Prevolen boots on. Small blister to left heel. No s/s (signs/symptoms) of infection...Reddened Skin...Nose...Area to bridge of nose is oozing and breakdown from BIPAP mask. Drsg (dressing) is present." His treatment flow sheet listed his Braden score as 12 and 13. 9/14/07: right side from 8:00 AM to 12:00 PM, and laying on his left side from 6:00 PM to 10:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 10:00			

	9/15/07: supine from 6:00 PM to 10:00 PM. His record documented he had received barrier cream and a bed pad change at 8:00 PM. His nursing assessment stated "skin Breakdown…Bottom…area has slight bleeding spots on bottom. (sic) center. (sic) of wound is black and necrotic (sic). Out side (sic) edges of wound appear to be peeling away...Reddened Skin...Nose...Area is scabbed and reddened in the midline." His treatment flow sheet listed his Braden score as 14 and 9. 9/16/07: His nursing assessment stated "Skin Breakdown…Bottom…large area on bilateral checks (sic) that are stage 3 ulcers with some areas of bleed. (sic) middle of right butt check (sic) wounds is black and necrotic…Contusion/Hematoma…R (right) Heel…4cmx2cm...Reddened Skin...Nose...area is scabbed with large wound at the bridge of nose." His treatment flow sheet listed his Braden score as 15. 9/18/07: His nursing assessment stated "Skin Breakdown…Bottom…Black escar (sic) noted on left buttock/coccyx area, deep area open on both side…Contusion/Hematoma…R (right) Heel…4cmx2cm…Right heel approx 1.5 inchx1 inch black circle, closed…left heel has eraser sized black area...Reddened Skin...Nose...Scabbed area - ointment applied..." His treatment flow sheet listed his Braden score as 15.			

The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours. Additionally, the wound to his left heel, noted on 9/11/07, was not again documented on until 9/18/07. Further, his EMTEK under the "ACTIVITY Position" documented he continued to not be repositioned appropriately as follows:

9/19/07: His nursing assessment stated "Skin Breakdown...Bottom...(checked dressing clean, dry, intact. Breakdown has quarter-sized area of necrotic tissue in center...Contusion/Hematoma...R (right) Heel...4cmx2cm...blood blister present in 4x2 cm area on heel. Prevalon boots on...Reddened Skin...Nose...scabbed over. Dime-sized. Bacitracin ointment applied." His treatment flow sheet listed his Braden score as 16 and 12.

9/21/07: supine from 8:00 AM to 12:00 PM. His record also documented he had received a bed bath and linen change at 10:15 AM. His CWOCN note stated "Nose is healing well and escar (sic) is resolving. Coccyx ulcer with black escar (sic) resolving, deeper with debridement and base with yellow slough. I conservatively removed and new granular tissue is present. No odor or signs of acute infection. Notified (physician's name) of confusion with who was coming to debride wound and suggested that patient could benefit from debridement. Patient should continue air overlay if DC'd (discharged) to ECF (extended care facility). Same wound care needed. Could benefit from alginate now in wound base. It now has some depth. I wrote out these recommendations (sic) and attached to the DC (discharge) orders..." His treatment flow sheet listed his Braden score as 14.

	9/22/07: left side from 12:00 AM to 8:00 AM and on his right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:15 PM. His nursing assessment stated "Wound base is covered greater than 50% with thick, yellow slough. Unknown if discharge will take place on Sun or Mon." His treatment flow sheet listed his Braden score as 15 and 14. 9/23/07: A physician's progress note stated "Surgery I have examined Pt's (patient's) sacral decubitus ulcer. It seems as though another surgeon was initially consulted to evaluate this problem. Currently, my opinion is that the wound looks reasonable clean with granulation noted. I would not be interested in debriding the wound @ this time, as less aggressive measures are working." His treatment flow sheet listed his Braden score as 16. 9/24/2007: His nursing assessment stated "...Coccyx large red to pink open area with no s/s (signs/symptoms) of infection, signs of healing noted, dressing changed per orders...Contusion/Hematoma...R (right) Heel...4cmx2cm...No c/o (complaints of) tenderness, heel in bootie and floated...Reddened Skin...Nose...Brown scab noted on bridge of nose, no s/s (signs/symptoms) of infection or drainage noted...Padding placed under BiPAP mask." A CWOCN note stated "Nose eschar continues with no redness - decreasing in size - dry. Right heel eschar is dry - no drainage - to be transferred today..." His treatment flow sheet listed his score as 13.			

9/25/07: His nursing assessment stated "Skin Breakdown…Bottom…Dressing intact, white thick drainage noted at center of wound, edges pink to red with evidence of healing noted…R (right) heel…4cmx2cm…" His treatment flow sheet listed his Braden score as 15.

9/26/07: His nursing assessment stated "Skin Breakdown…Bottom…Dressing clean, dry, intact. Wound edges pink to red. Small amount of thick white drainage in center of wound. No s/s (signs/Symptoms) of infection…R (right) heel…4cmX2cm…Reddened Skin…Nose...No dressing; small scab present, no s/s (signs/symptoms) of infection. Evidence of healing present. Bacitracin ointment applied." A Braden score was not recorded on his treatment flow sheet.

9/27/07: "Skin Breakdown…Bottom…Not assessed at this time." His treatment flow sheet listed his Braden score as 14.

9/28/07: Patient #33 was discharged to an Extended Care Facility.

9/28/07: Patient #33 was discharged to an Extended Care Facility.

Patient #33 was not provided with appropriate and timely care for his pressure wounds. The facility's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" and "BRADEN SCALE for Predicting Ulcer Risk" policies were not implemented. Patient #33's record did not include documentation that he was consistently reposition every 2 hours with small shifts in position and his records did not consistently reflect his wound status and interventions. The Supervising RN failed to ensure Patient #33's care was appropriately evaluated on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy.

Patient #25 was admitted to the hospital on 8/7/07 and was discharged on 8/17/07. The patient was a 74 year old male who had an aortic valve replacement and coronary artery bypass. His medical record did not include documentation that he was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy as follows:
8/7/07: His treatment flow sheet listed his Braden score as 22 prior to surgery and 14 after surgery.

8/8/07: His treatment flow sheet listed his Braden score as 12 and 15.

8/9/07: The "ACTICITY Position" section of his EMTEK documented no evidence that he had been repositioned every 2 hours. The EMTEK documented that he was supine from 4:00

	AM to 8:00 AM and from 10:00 AM to 4:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 6:00 AM, 11:00 AM and 12:00 PM and that a rotation mattress was initiated at 11:00 AM. His treatment flow sheet listed his Braden score as 14 and 17. His nursing notes stated he had a skin impairment of reddened skin on his left buttocks due to pressure. The notes documented at 8:00 AM, "1x2 cm purple pressure sore, skin intact, protective barrier cream applied." His nursing notes also documented he had a skin impairment of reddened skin on his right posterior upper thigh due to pressure. The notes documented at 8:00 AM, "No dressing 1/4 purple pressure sore, skin intact, protective barrier cream applied." His nursing assessment at 6:25 PM stated "...Pressure sores on back side, intact, change out bed to specialty one w/rotation feature..."			

	8/9/07: The "ACTICITY Position" section of his EMTEK documented no evidence that he had been repositioned every 2 hours. The EMTEK documented that he was supine from 4:00 AM to 8:00 AM and from 10:00 AM to 4:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 6:00 AM, 11:00 AM and 12:00 PM and that a rotation mattress was initiated at 11:00 AM. His treatment flow sheet listed his Braden score as 14 and 17. His nursing notes stated he had a skin impairment of reddened skin on his left buttocks due to pressure. The notes documented at 8:00 AM, "1x2 cm purple pressure sore, skin intact, protective barrier cream applied." His nursing notes also documented he had a skin impairment of reddened skin on his right posterior upper thigh due to pressure. The notes documented at 8:00 AM, "No dressing 1/4 purple pressure sore, skin intact, protective barrier cream applied." His nursing assessment at 6:25 PM stated "...Pressure sores on back side, intact, change out bed to specialty one w/rotation feature..." 8/10/07: His treatment flow sheet listed his Braden score as 10. His nursing notes at 8:00 AM stated "left buttocks…Skin intact but reddened" and "upper thigh…Skin intact." 8/11/07: His treatment flow sheet listed his Braden score as 12. His 8:00 AM nursing notes stated "left buttocks…Skin intact but reddened" and "upper thigh…2 inch area of dark red skin, skin intact."			

	8/12/07: His treatment flow sheet listed his Braden score as 15. His 7:30 AM nursing notes documented "left buttocks…Approximately the size of a pencil eraser, opened with slight bleeding noted" and "upper thigh…irregular oval shaped reddened pressure area noted. Skin intact. Approx 1/2 inch in length." 8/13/07: His treatment flow sheet listed his Braden score as 18. His 8:00 AM, nursing notes documented "left buttocks…area is covered with barrier cream. Area is beginning to heal" and "upper thigh…no dressing, covered with barrier cream." Additionally, at 8:00 PM, his nursing notes documented he had a skin integrity impairment of skin breakdown on the back of his head. The notes stated "Area reddish purple colored approx size of quarter, Pt (patient) using head doughnut." Patient #25's record did not include documentation that staff covered the open wound on his left buttocks with a foam or non-adherent dressing every 24=48 hours per the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE: CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, there was no documented evidence that the CWOCN was consulted per the "BRADEN SCALE for Predicting Ulcer Risk" policy due to his low Braden scores (i.e., 13 or below as documented on 8/8, 8/10 and 8/11/07). His medical records further documented the following:			
	8/9/07: The "ACTIVITY Position" section of his EMTEK documented no evidence that he had been repositioned every 2			

	hours. The EMTEK documented that he was supine from 4:00 AM to 8:00 AM and from 10:00 AM to 4:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 6:00 AM, 11:00 AM and 12:00 PM and that a rotation mattress was initiated at 11:00 AM. His treatment flow sheet listed his Braden score as 14 and 17. His nursing notes stated he had a skin impairment of reddened skin on his left buttocks due to pressure. The notes documented at 8:00 AM, "1x2 cm purple pressure sore, skin intact, protective barrier cream applied." His nursing notes also documented he had a skin impairment of reddened skin on his right posterior upper thigh due to pressure. The notes documented at 8:00 AM, "No dressing 1/4 purple pressure sore, skin intact, protective barrier cream applied." His nursing assessment at 6:25 PM stated "...Pressure sores on back side, intact, change out bed to specialty one w/rotation feature..." 8/10/07: His treatment flow sheet listed his Braden score as 10. His nursing notes at 8:00 AM stated "left buttocks…Skin intact but reddened" and "upper thigh…Skin intact."			
	8/11/07: His treatment flow sheet listed his Braden score as 12. His 8:00 AM nursing notes stated "left buttocks…Skin intact but reddened" and "upper thigh…2 inch area of dark red skin, skin intact." 8/12/07: His treatment flow sheet listed his Braden score as 15. His 7:30 AM nursing notes documented "left buttocks…Approximately the size of a pencil eraser, opened with slight bleeding noted" and "upper thigh…irregular oval shaped reddened pressure area noted. Skin intact. Approx 1/2 inch in length." 8/13/07: His treatment flow sheet listed his Braden score as 18. His 8:00 AM, nursing notes documented "left buttocks…area is covered with barrier cream. Area is beginning to heal" and "upper thigh…no dressing, covered with barrier cream." Additionally, at 8:00 PM, his nursing notes documented he had a skin integrity			

	impairment of skin breakdown on the back of his head. The notes stated "Area reddish purple colored approx size of quarter, Pt (patient) using head doughnut." Patient #25's record did not include documentation that staff covered the open wound on his left buttocks with a foam or non-adherent dressing every 24=48 hours per the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE: CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, there was no documented evidence that the CWOCN was consulted per the "BRADEN SCALE for Predicting Ulcer Risk" policy due to his low Braden scores (i.e., 13 or below as documented on 8/8, 8/10 and 8/11/07). His medical records further documented the following: 8/14/07: His treatment flow sheet listed his Braden score as 17. His 8:00 AM, nursing notes stated "left buttocks...Reddened and wound is open and appears to be in early stages of healing...barrier applied" and "upper thigh...Reddened/purplish in color barrier applied. Skin appears to be intact." Additionally, the notes documented "back of head...Remains reddish/purple in color. Skin is intact. Donut (sic) remains in place." 8/15/07: His treatment flow sheet listed his Braden score as 17 and 19. His 8:00 AM nursing notes stated "left buttocks...No dressing, remains reddened, barrier applied" and "upper thigh...No dressing." Additionally, his nursing notes documented "back of head...Remains intact, purplish in color." 8/16/07: His treatment flow sheet listed his Braden score as 20. His 8:00 AM nursing notes stated "left buttocks...No dressing, surrounding skin red, wound yellow, no drainage. Skin barrier ointment prn." Additionally, the notes stated "back of head...No dressing, wound scabbed over, no drainage." 8/17/07: The "ACTIVITY Position" section of the Treatment Flow sheet documented Patient #25 was sitting in a chair from 4:00 AM until 6:00 PM. Documentation the patient was			

repositioned every 2 hours was not present in the patient's record. The notes documented he walked 140 feet at 12:00 PM and 280 feet at 4:00 PM. A Braden score was not listed on his treatment flow sheet. His 8:00 AM nursing notes documented "upper thigh...scabbed area approximately 3 cm diameter; no s/s (signs or symptoms) infection."

Despite developing no less than 3 pressure ulcers, Patient #25's medical records did not include documented evidence that the CWOCN was consulted. On 11/9/07 at 9:40 AM, a CWOCN confirmed the CWOCN department was not consulted by nursing staff about Patient #25's pressure ulcers.

Patient #25 was not provided with appropriate and timely care for his pressure wounds. The facility's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" and "BRADEN SCALE for Predicting Ulcer Risk" policies were not implemented in response to Patient #25's Braden scores and his development of pressure ulcers. Further, Patient #25's record did not include documentation that he was consistently reposition every 2 hours with small shifts in position. The Supervising RN failed to ensure Patient #25's care was appropriately evaluated on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy.

Patient #24 was admitted to the hospital on 8/2/07 and was discharged on 8/23/07. The patient was a 80 year old male who had a history of underlying coagulopathy related to alcoholic hepatitis. At the time of his admission, he had a Braden scale score of 14 (Moderate Risk Score, supplement turning with small shifts in position such as increased turning with a 30 degree foam wedge or pillows, provide appropriate pressure reducing support surface such as a specialty mattresses or specialty padded boots). Patient #24's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. Additionally, his medical record documented the following:

8/9/07: At 8:00 AM the "Integumentary/Skin" section of his

	nursing notes documented "Reddened Skin...Buttocks...skin is red, blanches, barrier cream applied, instructed pt (patient) to turn to his side as much as possible." 8/12/07: At 4:30 PM the "Integumentary/Skin" section of his nursing notes documented "Reddened Skin...Buttocks...Reddened, position shifted." At 8:00 PM the notes documented "reddened area on coccyx placed on left side encouraged to stay if possible." At 10:00 PM the notes stated "placed on left side but changes positions" and at 3:00 AM the notes stated "assisted to left side pillows placed to keep of (sic) coccyx area." 8/13/07: At 8:00 AM the "Integumentary/Skin" section of his nursing notes documented "reddened area noted buttocks area with skin breakdown, no drainage." 8/14/07: At 8:00 PM the "Integumentary/Skin" section of his nursing notes documented "coccyx is reddened (sic). No s/s (signs/symptoms) of breakdown."			
	8/15/07: At 12:00 AM the "Integumentary/Skin" section of his nursing notes documented "Coccyx is red but intact. Pt (patient) will not lie on his sides so is on his back all the time." At 8:00 AM the notes documented "Coccyx (sic) is red, dry and intact. Pt. (Patient refuses to lie on his sides." 8/21/07: At 11:18 AM the "Integumentary/Skin" section of his nursing notes documented "Pt has 2 small areas of breakdown on coccyx. Wound care nurse aware. Airbed and xenaderm ordered." At 4:00 PM the notes documented "Two small areas of break down. Xenaderm applied and pt (patient) turned on left side." Additionally, the 8/21/07 "Prevalence Report" documented Patient #24 was at risk and had developed a unit acquired, stage 2 pressure ulcer on his buttocks. However, there was "No Evidence" of "pressure Ulcer Prevention" measures being used beyond nutritional support according to the report. His nursing assessment further stated at 3:30 PM an air bed was initiated, per			

	suggestion of the 8/21/07 prevalence study and a CWOCN note at 7:45 AM stated xenaderm ointment was to be used twice daily and as needed and the patient was to be assisted or reminded to run every two hours. 8/22/07: At 12:00 AM the "Integumentary/Skin" section of his nursing notes documented "Breakdown on (sic) Right Buttock (sic), dime size, blanches at 3 seconds, pink and skin is broken at surface. Left buttock is pink and blanches well, skin intact, Xenoderm applied to both sites." At 8:00 AM the notes stated "Small open area on right coccyx. Redness over several inch area, right and left coccyx. Xenaderm being used." 8/23/07: Patient #24 was discharged from the hospital. Patient #24's record did not contain documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. He was not provided with an appropriate pressure reducing support surface as per policy until 8/21/07. On 11/9/07 at 9:10 AM, a CWOCN nurse confirmed the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer until 8/21/07, the day of the prevalence study. The nurse also confirmed the above documentation. The Supervising RN failed to ensure Patient #24 received appropriate preventative care which was consistent with the Braden scale policy interventions. Patient #23 was admitted to the hospital on 8/16/07 and was discharged on 8/23/07. The patient was an 87 year old female who had a ground level fall and had a history of degenerative joint disease of the spine and hip. She also had a history of diabetes with chronic renal insufficiency. Her medical record documented she did not receive wound care in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION and DEBRIDEMENT" policy as follows: 8/16/07: At 1:00 PM EMTEK notes documented "Skin Breakdown...sacrum...small open area 1inx1/4 in w/surrounding			

	redness. Cream applied." 8/17/07: At 8:00 PM EMTEK notes documented barrier cream was applied. 8/18/07: At 8:00 PM EMTEK notes documented "Skin Breakdown...sacrum...Red with no drainage, barrier applied no dressing. 8/19/07: At 8:00 AM EMTEK notes documented no breakdown noted. However, EMTEK notes at 8:00 PM documented "Skin Breakdown...sacrum...Healing without s/s (signs/symptoms) of infection." 8/20/07: At 8:00 AM EMTEK notes documented "Skin breakdown...sacrum...reddened, skin intact." 8/21/07: At 8:00 AM EMTEK notes documented "skin breakdown...sacrum...blanchable half dollar sized red area on left upper buttock." Additionally, the hospital's 8/21/07 "Prevalence Report" documented Patient #23 was at risk and had developed a hospital and a unit acquired pressure ulcer. The report documented she had developed a stage 1 and a stage 2 pressure ulcer and that there was "No Evidence" of "Pressure Ulcer Prevention" measures being used. However, summary documentation of the 8/21/07 "Prevalence Study" documented a stage 1 hospital acquired pressure ulcer on her spine. However, the summary did not include documentation of the pressure area on her sacral area. 8/22/07: At 8:00 PM EMTEK notes documented "Skin breakdown...sacrum...stage 2 coccyx (sic) area, open to air, no drainage." 8/23/07: Patient #23 was discharged. Patient #23's record did not contain consistent documentation related to her skin integrity. Additionally, there was no			

	documented evidence that nursing staff followed the hospital's policy in caring for Patient #23's stage 2 pressure ulcer (cleansing with normal saline, using skin prep, applying barrier cream twice daily, and covering with a foam or non-adherent dressing) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Further, there was no documented evidence that the CWOCN Nurse was consulted regarding the open wound. On 11/9/07 at 9:30 AM, a CWOCN nurse confirmed the CWOCN department was not consulted by nursing staff about the patient's pressure ulcer. The Supervising RN failed to ensure Patient #23 received appropriate care which was consistent with the WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Patient #57 was admitted to the hospital on 9/16/07 and was discharged on 10/2/07. The patient was a 67 year old female who had a history of amyloidosis and end stage renal disease managed with peritoneal dialysis. Her medical record did not include documentation that she was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy as follows: The "Integumentary/Skin" section of her nursing assessments, dated 9/16/07 to 9/22/07, documented her skin was warm, dry and of normal color. Her Braden score for 9/20/07 was 19 and her 9/21/07 Braden scores were 19 and 18. Her record documented the following: 9/22/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated "...Skin Breakdown...buttocks...Area is reddened. Pea			

	sized scabbed area to coccyx. No s/s (signs/symptoms) of infection noted. Will order (sic) wound care consult." 9/23/07: Her treatment flow sheet listed her Braden score as 16. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM"...Skin Breakdown...buttocks...Buttocks is reddened with dime sized scabbed area to coccyx. No s/s (signs/symptoms) of infection." 9/24/07: Her treatment flow sheet listed her Braden score as 16. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...Skin around scrape is inflamed, center of wound is yellow/white...Reddened Skin...R (right) and L (left) heels...Skin on heels is red but blanches." A CWOCN note at 1:43 PM stated "stage III of buttocks - has open red and yellow slough areas of bilateral buttocks and coccyx area. 6x6 cm - no depth to it - patient can turn self. Has sitter. Criticaid applied to the area - orders written to apply tid (three times daily) and prn (as needed). Turn side to side every 2 hours..." 9/25/07: Her treatment flow sheet listed her Braden score as 14. The "Integumentary/Skin" section of her nursing assessment stated at 9:00 AM, "...Skin Breakdown...buttocks...No dressing, stage II pressure ulcer, treating with soap and water cleanse and skin protectant cream..." The assessment also stated "...Reddened Skin...R (right) and L (left) heels...No dressing, skin is red, slightly boggy, no signs of further breakdown..." 9/26/07: Her treatment flow sheet listed her Braden score as 16 and 12. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...Buttocks is red. Two areas of yellow. Wound care to see." The assessment also stated "...Reddened Skin...R (right) and L (left) heels...red, will elevate..." At 4:00 PM, the "Integumentary/Skin" section of her nursing assessment stated "...Reddened Skin...R (right) and L (left) heels...Slightly reddened. Will float heels." Additionally, a CWOCN note, dated 9/26/07 at 5:30 PM, stated "pt (patient) placed on first step mattress. She is			

	unable to attain a position of comfort on standard hospital mattress per staff RN..."			
	9/27/07: Her treatment flow sheet listed her Braden score as 14 and 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...Area reddened, no s/s infection..." The assessment also stated "...Reddened Skin...R and L heels...Area reddened, no s/s breakdown, heels elevated..." At 8:00 PM, the "Integumentary/Skin" section of her nursing assessment stated "...Skin Breakdown...buttocks...Skin is red with open area with little to no drainage. Wound cleaned and treated with topical cream..." The assessment also stated "...Reddened Skin...R and L heels...Skin remains red, ted hose replaced..." 9/28/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...reddened area with yellow center noted to coccyx, area cleansed and ointment applied..." The assessment also stated "...Reddened Skin...R and L heels...reddened..." 9/29/07: Her treatment flow sheet listed her Braden score as 17 and 14. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 PM, "...Skin Breakdown...buttocks...skin is red with little to no drainage from open area." 9/30/07: Her treatment flow sheet listed her Braden score as 17. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 PM, "...Skin Breakdown...buttocks...Area reddened with yellow noted to center, area cleaned and topical cream applied..." The assessment also stated "...Reddened Skin...R and L heels...reddened, elevated off bed..." 10/1/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 PM, "...Skin Breakdown...buttocks...(checked)			

Dressing clean, dry, intact..." The assessment also stated "...Reddened Skin...R and L heels...reddened..." Additionally, a CWOCN note at 1:57 PM stated "Patient with open skin breakdown of the buttocks - yellow slough and red open areas - applied criticaid with antifungal to the area - covered with saran wrap to keep it on the skin..."

10/2/07: Patient 57 was discharged from the hospital. Despite documentation that a wound consult was to be ordered on 9/22/07, Patient #57 was not seen by the CWOCN until 9/24/07. In the interim, the patient's EMTEK did not document nursing had followed hospital polices and cleansed the pressure ulcer with normal saline, used skin prep around wound edges, loosely packed the wound with gauze and wound gel or saline and changed with dressings every 24-48 hours.

The Supervising RN failed to ensure Patient #57 received appropriate care which was consistent with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy.

Patient #59 was admitted to the hospital on 10/29/07 and discharged on 11/5/07. The patient's History and Physical, dictated at 4:35 PM on 10/29/07, stated the patient was a 94 year old female with a history of coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, moderate dementia, status post pacemaker, and a history of TIA's. She presented to the ED and was admitted due to acute shortness of breath. The history and physical stated Patient #59 also had recent admissions to the hospital in August and September for supposed CHF exacerbations. It also noted the patient's right leg was bandaged due to a previous wound on the right shin. A Treatment Flow sheet in the patient's record documented a Braden scale score of 13 at 6:00 PM on 10/29/07.

The patient's EMTEK under the ACTIVITY Position section did not contain documented evidence the patient had been repositioned every 2 hours or was provided supplemental turning with small shifts in position during the following dates and times:

	10/29/07: supine from 5:45 PM to 10:00 PM and remained supine from being repositioned at 10:00 PM until 10/30/07 at 6:00 AM. At 6:00 PM an RN documented in the Assessments' Notes section of the patient's record "Integrity Impairment (Skin Breakdown)., R lower calf: Dressing clean, dry, intact. Not assessed at this time." RN documentation in the same section of the patient's record at 8:00 PM stated "Integrity Impairment (Skin Breakdown)., R lower calf: Dressing clean dry intact." 10/30/07: supine from 6:00 AM to 2:00 PM. An 8:00 AM RN nursing note stated the bandage was removed from the wound on the patient's right calf to find green ointment in the wound. No further information regarding the wound was documented by the RN. Also at 8:00 AM the patient's Treatment Flowsheet documented a Braden Scale score of 16. A CWOCN nursing note, at 2:00 PM stated "patient known to service from previous hospitalization - has an open wound on back of left calf - spoke with center for wound healing and hyperbaric medicine state that the treatment plan was a wound VAC with unna boot - when dressing removed panafill was in place on a exudry - spoke with nurse at (care center patient was admitted from) states that the wound VAC was stopped because of pain and orders were obtained, they believed, from their resident physician - will place wound gel on patient at this time with gauze dressing - and allevyn foam-wrap with kerlix." 10/30/07: as sitting in a chair 4:00 PM to 8:00 PM. Hygiene activities and a linen change were noted on the patient's Treatment Flow sheet at 4:00 PM. An RN nursing note documented at 8:00 PM that the dressing on Patient #59's calf wound was clean, dry, and intact. 10/31/07: supine from 11:00 AM to 2:02 PM, at which time a PT assessment was completed and on the right from 8:00 PM to 12:00 AM 11/1/07. On 10/31/07 at 12:00 AM an RN nursing note stated Patient #59's gown and bedding were wet from a leak in her foley catheter. At 8:00 AM an LPN nursing note indicated the dressing on the patient's calf wound was clean, dry, and intact. A			

	Braden Scale score of 16 was also documented in the Treatment Flowsheet at the same time. An LPN documented an assessment of Patient #59's skin integrity at 5:30 PM. The assessment included a new pressure sore "...Nickel sized purple, and reddened area to buttocks, skin breakdown. Pt turned off of buttocks and advise to stay off of her buttocks. Skin is intact and no s/s of infection noted. Pt will be turned every 2 hours." The skin breakdown on the patient's buttocks was also noted by an LPN in a nursing note at 7:28 PM and an RN nursing note at 8:00 PM. The only documentation of the status (size, shape) of Patient #59's calf wound was found in an LPN nursing note on 10/31/07 at 3:00 PM. The note stated "Wound is larger than a silver dollar in size, no s/s of infection noted with some bloody, serous drainage on the old dressing." 11/1/07: supine from 12:00 AM to 6:00 AM and supine from 12:00 PM to 2:45 PM and again from 10:00 PM to 8:00 AM on 11/2/07. An RN nursing note at 10:05 PM indicated the skin breakdown on the patient's calf had a dressing that was clean, dry, and intact and the skin breakdown on her buttocks was described as "Area reddened. No sign of open skin." A PT note at 2:45 PM stated the patient refused PT in the morning due to fatigue, but participated in the afternoon. The PT note began by stating "Pt supine..." An RN note at 8:00 PM stated the same for the calf wound and stated the buttocks wound had no dressing and was dry and red. A Braden Scale score of 15 was also documented on the patient's Treatment Flow sheet at 8:00 PM. 4:00 AM on 11/3/07, however, the patient refused a position change. 11/3/07: supine at 12:00 PM and there was no further documentation of a different position until 2:00 PM on 11/4/07. A Braden Scale score of 14 was documented, at 8:00 AM and 8:00 PM on 11/3/07, on the Treatment Flow sheet section of the patient's record. PT documentation at 3:54 PM indicated the patient refused AM and PM PT due to fatigue. 11/4/07: left side at 4:00 PM and there was no further			

documentation of a different position until 12:00 AM on 11/5/07. A Braden Scale score of 11 was documented on the patient's Treatment Flow sheet at 8:00 AM. A nursing note at the same time documented the calf wound as having a clean, dry, and intact dressing and the buttocks wound as having redness and xenaderm applied. At 8:00 PM a nursing note documented the dressing on the calf wound was changed and the buttocks wound described as reddened and xenaderm applied. The one PT note documented for the day at 2 PM stated the patient declined PT due to fatigue and that the patient had thoracentesis earlier in the day.

11/5/07: A Braden Scale score of 10 was documented at 8:00 AM. A PT note at 9:30 AM stated Patient #59 participated in PT at that time. Patient #59 was discharged to a nursing facility at 4:15 PM with comfort measures in place.

On 11/9/07 at 10:40 AM, a CWOCN nurse confirmed the above documentation and stated it was the hospital's best practice to turn patients at least every 2 hours. The hospital failed to ensure Patient #59 was provided with services necessary to prevent skin breakdown and that the status of her wounds was consistently documented to monitor healing or lack thereof.

Note: A395 continued at A9999
CLOSING COMMENTS
CONTINUED FROM:
a395: 482.23(b)(3) RN SUPERVISION OF NURSING CARE
A registered nurse must supervise and evaluate the nursing care for each patient.
Patient $56 was a 23 year old male. He was admitted on 8/28/07 with paraplegia following a motorcycle accident. He was transferred to a rehabilitation unit on 9/27/07.
His medical record did not include documentation that he was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, his EMR under "ACTIVITY Position" did not document evidence that he had been repositioned every 2 hours or was provided

	supplemental turning with small shifts in position during the following dates and times: 8/28/07: His treatment flow sheet listed his Braden score as 10. 8/29/07: His treatment flow sheet listed his Braden score as 8 and 10. 8/30/07: His treatment flow sheet listed his Braden score as 10, 9 and 9. 8/31/07: His treatment flow sheet listed his Braden score as 7. 9/1/07: His treatment flow sheet listed his Braden score as 13. Position documented as supine from 10:00 AM until 10:00 PM. 9/2/07: His treatment flow sheet listed his Braden score as 11 and 10. Position documented as supine from 4:00 AM until 9:56 AM when PT did passive exercise. 9/3/07: His treatment flow sheet listed his Braden score as 11 and 13. 9/4/07: His treatment flow sheet listed his Braden score as 11 and 11. Position documented as supine from 4:00 AM until 10:00 AM and again supine from 2:00 PM until 10:00 PM. 9/5/07: His treatment flow sheet listed his Braden score as 14 and 12. 9/6/07: His treatment flow sheet listed his Braden score as 14 and 11. 9/7/07: His treatment flow sheet listed his Braden score as 12 and 10. 9/8/07: His treatment flow sheet listed his Braden score as 11 and 12. Position documented as on right side from 6:00 PM until 10:00 PM.			

	9/9/07: His treatment flow sheet listed his Braden score as 13. Position documented as supine from 4:00 PM until 2:00 AM on 9/10 with supplemental repositioning (not turning) at 6:00 PM and 10:00 PM. 9/10/07: His treatment flow sheet listed his Braden score as 15. Position documented as supine from 4:00 AM until 12:00 PM. 9/11/07: His treatment flow sheet listed his Braden score as 12 and 13. Position was documented as supine from 2:00 AM until 8:00 AM. He was on his right side from 8:00 AM until 11:00 AM when PT transferred him to the chair. He sat in the chair from 12:00 PM until 6:00 PM. Position documented as supine from 8:00 PM until 12:00 AM. He refused repositioned at 10:00 PM. 9/12/07: His treatment flow sheet listed his Braden score as 12. Position documented as supine from 12:00 AM until 10:00 AM. He refused repositioning at 4:00 AM. He was in the chair from 10:00 AM until 6:00 PM. 9/13/07: His treatment flow sheet listed his Braden score as 13. Position documented as right side from 2:00 AM until 8:00 AM. Position documented as supine from 8:00 AM until 1:30 PM when PT did range of motion exercises. Continued to remain supine until 8:00 PM. 9/14/07: His treatment flow sheet listed his Braden score as 11. Position documented as supine from 2:00 AM until 10:00 AM when supplemental repositioning was done. Continued supine until 12:00 PM. Position documented as left side from 12:00 PM until 4:00 PM. Position documented as supine from 4:00 PM until 12:00 AM on 9/15 when the head of the bed was lowered. 9/15/07: His treatment flow sheet listed his Braden score as 12. Position documented as left side from 12:44 AM until 11:22 AM when PT did range of motion exercises. Position documented as supine from 12:00 PM until 4:445 PM when PT transferred him to the chair. Position continued to be documented as supine until			

	12:00 AM on 9/16. He refused repositioning at 10:00 PM. 9/16/07: His treatment flow sheet listed his Braden score as 13. Position documented as supine from 4:00 AM until 10:00 AM with supplemental repositioning (not turning) at 8:00 AM. Position documented as right side from 10:00 AM until 2:56 PM when PT transferred him to the chair. No position was documented until 8:00 PM. Position documented as supine from 8:00 PM until 12:00 AM on 9/17. 9/17/07: His treatment flow sheet listed his Braden score as 12. Position documented as left side from 12:00 AM until 8:00 AM. He was up in the chair from 10:00 AM until 6:00 PM. 9/18/07: His treatment flow sheet listed his Braden score as 9. Position documented as supine from 12:00 AM until transferred to the chair by PT at 1:10 PM. He refused to turn at 4:00 AM and 10:00 AM. 9/19/07: His treatment flow sheet listed his Braden score as 12. Position documented as supine from 12:00 AM until PT transferred him to the chair at 3:00 PM. Position documented as in chair until 10:00 PM. He refused repositioning at 12:00 AM and 4:00 AM. 9/20/07: His treatment flow sheet listed his Braden score as 12. Position was documented as supine from 12:00 AM until 10:00 AM. He refused turning at 2:00 AM. Supplemental repositioning was done at 4:00 AM and 8:00 AM. Nursing notes at 8:00 AM document "Breakdown noted to coccyx. Area the size of a quarter. Skin is broken." 9/21/07: His treatment flow sheet listed his Braden score as 17. Nursing notes document at 8:00 AM, "Skin Breakdown, Buttocks: No dressing". CWOCN intervened at 8:30 AM and ordered "smith and nephew dimeticone skin protective paste on area…" Further CWOCN documentation noted, "...patient has area of eschar on coccyx..." At 2:00 PM nursing documentation was, "Skin Breakdown, Buttocks: Cream applied; wound appears to be			

	healing without infection." At 8:00 PM nursing documentation was, "Skin Breakdown, Buttocks: No dressing". 9/22/07: His treatment flow sheet listed his Braden score as 15. Position documented as supine from 6:00 AM until 12:00 PM. Position documented as supine from 2:0o PM until 10:00 PM with supplemental repositioning (not turning) at 2:00 PM and 4:00 PM and passive range of motion exercises by PT at 3:21PM. Nurses notes document, "Skin Breakdown, Buttocks: turned to left side. Cream applied to sore" at 12:00 AM and at 8:00 PM. "Skin Breakdown, Buttocks: Healing without s/s of infection." 9/23/07: His treatment flow sheet listed his Braden score as 11. Position was documented as supine from 2:00 AM until 8:00 AM and up in the chair from 4:08 PM until 8:00 PM. Nurses notes documented at 8:00 AM, "Skin Breakdown, Buttocks: Skin broken wound bed red, size of quarter. Peri wound skin appears necrotic." At 6:57 PM nurses documented, "Open area to sacrum, pt turned, barrier cream applied". At 8:00 PM nurses documented, "Skin Breakdown, Buttocks: No dressing wound is dark red/purple in color. barrier cream applied per ET orders". 9/24/07 No Braden scale was assessed for this day. Position documented as left side from 4:00 AM until 10:00 AM and supine from 10:00 AM "Skin Breakdown, Buttocks: Necrotic area around open breakdown. Barrier cream applied, pt turned." At 8:00 PM nursing documentation included "Skin breakdown, Buttocks: Darkened area at coccyx appears to be healing, no s/s of infection, barrier cream applied per ET orders". CWOCN consult on this day documents at 4:00 PM, "f/u to Friday visit eschar still present small amount lifting on left side of the wound - will continue with smith and nephew dimecoine skin protection". 9/25/07: His treatment flow sheet listed his Braden score as 10. Position was documented as left side from 12:00 AM until 4:00 AM, on right side from 4:00 AM until 8:00 AM and supine from 8:00 AM until 1:59 PM when OT did active range of motion exercises. Nursing documentation indicated, at 8:00 AM, "Skin Breakdown, Buttocks: Small open area, wound bed pink. Necrotic			

	tissue falling off, healthy tissue underneath." 9/26/07: His treatment flow sheet listed his Braden score as 14. Position documented as supine from 5:00 PM until 10:00 PM with supplemental repositioning at 8:00 PM. Nursing documentation at 8:00 Am and again at 8:00 PM is as follows, "Skin Breakdown, Buttocks: Dressing clean, dry intact.". 9/27/07: His treatment flow sheet listed his Braden score as 14. No nursing documentation on wound status. Position documented as left side from 12:00 AM until 8:00 AM. Facility staff failed to provide the interventions recommended in the facility's Braden Scale policy prior to the CWOCN consult. On 25 days of the patient's 31 day hospital stay, his Braden Scale score was equal to or below 13. A CWOCN consultation was not initiated and an appropriate pressure reducing support surface was not provided according to the Braden Scale policy. CWOCN consultation was not done until the patient's 25th hospital day and after a decubitus had developed on his buttocks. An appropriate pressure reducing surface, in the form of an overlay mattress, was documented on the Treatment Flow sheet of the EMR as being initiated on 9/1/07, off on 9/3/07 and reinitiated 9/14/07. There was no documentation that the overlay mattress was in place on 9/4 - 9l/13/07 or on 9/23/07, 9/24/07 or 9/25/07. Patient #46 was an 87 year old female who was admitted on 8/11/07 with the diagnosis of left hip fracture. This was treated surgically on 8/12/07 and the patient was discharged on 8/20/07. Her medical record did not include documentation that she was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the "WOUND and PRESSURE< ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, her EMR under "ACTIVITY Position" did not document evidence that the patient had been repositioned every 2 hours or was provided supplemental turning with small shifts in position during			

	the following dates and times: 8/11/07: Her treatment flow sheet listed her Braden score as 15. Position was documented as supine from 8:00 PM on 8/11 until 4:00 AM on 8/12. 8/12/07: Her treatment flow sheet listed her Braden score as 12. 8/13/07: Her treatment flow sheet listed her Braden score as 11. Position documented as supine from 12:00 AM until 10:00 AM and again supine from 12:00 PM until 4:00 PM. 8/14/07: Her treatment flow sheet listed her Braden score as 13. CWOCN consult at 11:30 AM notes, "request to see patient for low Braden score - 14 patient turned has purple are along coccyx and along gluteal fold apparently for crease in linen - will place patient on 1st step mattress and write to limit linen on bed to dri-flo pad and turn patient every two hours. Xenaderm to area on buttocks BID". Position documented as right side from 8:00 PM until 12:00 AM. 8/15/07: Her treatment flow sheet listed her Braden score as 16. Position was documented as supine from 4:00 AM until 12:00 PM with supplemental repositioning (not turning) at 8:00 AM. Position documented as right side from 2:00 PM until 8:00 PM. 8/16/07: Her treatment flow sheet listed her Braden scores as 12 and 12. Her treatment flow sheet indicated she was a two person assist to turn. Position was documented as supine from 2:00 AM until 2:00 PM with supplemental repositioning (not turning) at 7:00 AM. Position documented as supine from 4:00 PM until 10:00 PM with supplemental repositioning (not turning) at 6:00 PM. Continued documentation of position as right side from 10:00 PM on 8/16 until 4:00 AM on 8/17 with supplemental repositioning (not turning) at 2:00 AM. A CWOCN note stated, "redden areas remain unchanged on bottom...will provide barrier for patient". 8/17/07: Her treatment flow sheet listed her Braden score as 17. Additionally, the treatment flow sheet indicated her turning			

	required 2 person maximum assistance. Position was documented as supine from 8:00 AM until 10:00 PM with supplemental repositioning (not turning) at 12:00 PM and 4:00 PM. Nursing notes documented, "Reddened Skin, Sacral: small approx blister appearing lesion at the top of the gluteal fold; slight redness .5x1 cm L gluteal area". 8/18/07: Her treatment flow sheet listed her Braden score as 15. Position was documented as supine from 12:00 AM until 4:00 AM and again from 6:00 AM until 12:00 AM on 8/19 with supplemental repositioning (not turning) at 8:00 AM, 8:30 AM, 9:15 AM, 10:00 AM, 2:00 PM and 6:00 PM. Nursing notes documented at 12:00 AM, "Reddened Skin, Sacral: No dressing, area reddish purplish in color." Documentation also included, at 8:00 AM, "Reddened Skin, Sacral: No Dressing". 8/19/07: Her treatment flow sheet listed her Braden score as 14. Position was documented as right side from 12:00 AM until 8:00 AM. Position documented as supine from 8:00 AM until 12:00 AM on 8/20 with supplemental repositioning (not turning) at 10:00 AM, 12:00 PM, 4:00 PM, 6:00 PM and 8:00 PM. Nursing documentation at 12:00 AM states, "Reddened Skin, Sacral: No dressing small blister top of gluteal folds, L side blister, open to air with no s/s of infection topical applied blister appears to be healing". Further documentation at 8:00 PM states, "Reddened Skin, Sacral: No dressing". 8/20/07: Her treatment flow sheet listed her Braden score as 18. Position was documented as supine from 4:00 AM until 11:00 AM with supplemental repositioning (not turning) at 6:00 AM, 8:29 AM and 10:00 AM. Facility staff failed to initiate the interventions recommended in the facility's BRADEN SCALE policy on 8/12/07 and 8/13/07. The policy stated that a score of 10-12 required, "1. Supplement turning with small shifts in position. 2. Provide appropriate pressure reducing support surface. 3. Dietary consult 4. CWOCN Consult for score equal to or less than 13."			

Saint Alphonsus

January 7, 2008

Sylvia Creswell
Idaho Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

Dear Ms. Creswell:

Attached please find Saint Alphonsus Regional Medical Center's plan of correction which is intended to address and rectify state licensure deficiencies cited during a survey concluded on November 20, 2007.

Since the deficiencies cited are substantially similar to those on the Statement of Deficiencies/Plan of Correction (CMS-2567) and we have already completed our Allegation of Compliance on that form, please reference those responses as specified in the attached form.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. The hospital takes the issues raised during the survey very seriously and have worked diligently to address each one.

We appreciate your thoughtful consideration of this plan of correction. Please contact Aline Lee, RN, Director of Patient Safety and Regulatory Compliance at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Sandra B. Bruce

Sandra B. Bruce
President and CEO

1055 North Curtis Road
Boise, ID 83706-1370
Phone: (208) 367-2121
www.saintalphonsus.org

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130007	A. BUILDING _____ B. WING _____	11/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTEI	1055 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the recertification and complaint investigation survey of your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Rae Jean McPhillips, RN, HFS Patricia O'Hara, RN, HFS Acronyms used in the survey report include: CHF = Congestive Heat Failure CWOCN = Certified Wound-Ostomy-Continence Nurse DNS= Director of Nursing ED = Emergency Department EMR = Electronic Medical Record EMTEK = Hospital's Electronic Documentation System ET = Certified Wound-Ostomy-Continence Nurse consult ICU = Intensive Care Unit Nsg = Nursing PI = Program Improvement PRN = As Needed PT = Physical Therapist Pt = Patient RN = Registered Nurse SARMC = ST Alphonsus Regional Medical Center TIA = Transient ischemic attack UE = Upper Extremity	B 000	RECEIVED JAN 14 2008 FACILITY STANDARDS	
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide	BB124	Please see response to tag A267 on CMS form 2567 submitted on 12/27/2007.	

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BB124	Continued From page 1 quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Based on review of clinical records, quality improvement documents, and staff interviews, it was determined the facility failed to ensure that the hospital-wide quality assurance program documented appropriate remedial actions to address deficiencies found through their Prevalence study program. The hospital did not document the outcome of the remedial action or track and analyze sufficient data necessary to adequately assess the hospital's services, operations, and processes of care related to the prevention and care of pressure ulcers. The findings include: 1. The CWOCNs' activity sheets documented the CWOCNs had seen patients with pressure ulcers at the following monthly rates: 8/07: 22 patients with pressure ulcers. Of the 22 patients, 19 were identified as having hospital acquired pressure ulcers. 9/07: 17 patients with pressure ulcers. Of the 17 patients, 6 were identified as having hospital acquired pressure ulcers. 10/07: 31 patients with pressure ulcers. Of the 31 patients, 28 were identified as having hospital acquired pressure ulcers. The hospital's "FY08 SARMC Quality and Safety Plan," dated 3/15/07, stated in the "Improve	BB124		

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BB124	Continued From page 2 Pressure Ulcer Indicator" section that the hospital was "Improving definitions and data collection tools and processes for quarterly prevalence study. Defining standards of nursing assessment and pressure ulcer prevention interventions [sic]." The facility's quality improvement document was a "Pressure Ulcer Prevalence Report" dated 8/21/07. The report was a facility wide screening that documented whether or not the patients had a pressure ulcer. The report consisted of a grid. Each column of the grid was labeled with patient information (i.e. room number, name, age, sex, admit date, etc.) and information related to pressure ulcers (i.e. Braden score, types of pressure ulcer prevention in use, number of ulcers, etc.). Each row of the grid represented a separate patient. When asked about the report on 11/16/07 at 9:43 AM, a CWOCN stated the report was completed one day each quarter, by completing a visual check of the patient and entering data on the grid which reflected each patient's status. The hospital's 8/21/07 "Prevalence Report" documented there were no less than 9 patients who had pressure ulcers. Of those 9 patients, the "Prevalence Report" documented 6 patients had developed hospital acquired pressure ulcers, which included but were not limited to the following: a. The row for Patient #24 on the 8/21/07 "Prevalence Report" stated the following: The first 6 columns documented his room number, name, MRN, age, sex, and admission date. The 7th column stated "Assessment Prior to	BB124		

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BB124	Continued From page 3 Survey." A "yes" was placed in the box. The 8th column stated "Braden Score." A "17" was placed in the box. The 9th column stated "Time Since Last Assessment." The box stated " >12 - 24 Hours." The 10th column stated "Pt [patient] at Risk." The box stated "Yes." The 11th column stated "Pressure Ulcer Prevention" and was subdivided into 3 columns labeled "Yes," "No Evidence" and "Not Applicable." A check mark was placed in the "No Evidence" box. The 12th column stated "Type of Pressure Ulcer Prevention in Use" and was subdivided into 4 columns labeled "Pressure Reducing Surface," "Repositioning," "Nutritional Support," and "Other." A check mark was placed in the column marked "Nutritional Support." The 13th column stated "Number of Ulcers" and was subdivided into 3 columns labeled "Total," " Hospital Acquired," and "Unit Acquired." A "1" was placed in the "Total" column and the "Unit Acquired" column. The 14th column stated "Number of Ulcers at Each Stage" and was subdivided into 5 columns labeled "Stage I," "Stage II," "Stage III," "Stage IV," and "Unstageable." A "1" was placed in the "Stage II" column. The 15th column stated "Ulcer Location(s) (Use Loc. Nbr. On figure)." The word "buttock" was placed in the box.	BB124		

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BB124	Continued From page 4 The 16th column stated "Patient on 02 [oxygen]" and was subdivided into 2 columns labeled "Yes" and "No." A checkmark was placed in the box under the "No" column. The 17th column stated "Ear Protectors or Mask" and was subdivided into 3 columns labeled "Yes," "No," and "NA." A checkmark was placed in the box under the "NA" column. The 18th column stated "Reason Patient Not Assessed" and was subdivided into 4 columns labeled "Not Available," "Patient Discharged," "Patient Refused," and "Contraindicated." The boxes were left blank for Patient #24. In summary, the "Prevalence Report" documented Patient #24 was at risk and had developed a unit acquired, Stage II pressure ulcer on his buttocks. However, there was "No Evidence" of "Pressure Ulcer Prevention" measures being used beyond nutritional support. Additionally, the "Integumentary/Skin" section of Patient #24's nursing notes documented "Reddened Skin ...Buttocks...skin is red, blanches, barrier cream applied, instructed pt [patient] to turn to his side as much as possible." The documentation was dated 8/9/07 at 8:00 AM, 11 days prior to the "Prevalence Report." Similar information related to the area was documented in his nursing notes dated 8/12/07, 8/13/07, 8/14/07, 8/15/07, and 8/21/07. His record also documented on 8/21/07 at 3:30 PM an air bed was initiated, per suggestion of the 8/21/07 prevalence study. The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, was not sufficient to ensure Patient #24 received timely	BB124		

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BB124	Continued From page 5 and appropriate preventative care related to his skin integrity. The study did not document patient specific day to day data to identify specific quality indicators (i.e., the review and assessment of Patient #24's care record for compliance of repositioning, implementation and adherence to the hospital's wound and Braden scale policies and other such operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). b. The 8/21/07 "Prevalence Report" included a row for Patient #25. In summary, the "Prevalence Report" documented Patient #25 was at risk and had developed a hospital acquired Unstageable pressure ulcer on his head. The report documented there was "No Evidence" of "Pressure Ulcer Prevention" measures being used. However, Patient #25's nursing notes dated 8/9/07 at 8:00 AM documented he had developed a "1x2 cm purple pressure sore" on his left buttocks and a "1x4 purple pressure sore" on his right posterior upper thigh. The notes documented that a rotation mattress was initiated on 8/9/07 at 11:00 AM. Similar information related to the pressure areas on Patient #25's thigh and buttocks was documented in his nursing notes dated 8/10/07, 8/12/07, and 8/13/07. The nursing notes on 8/13/07 at 8:00 PM also documented he had developed skin breakdown on the back of his head. The notes stated "Area reddish purple colored approx size of quarter, Pt [patient] using head doughnut." Similar information regarding the pressure areas on his thigh, buttocks, and head was documented in his nursing notes dated	BB124		

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BB124	Continued From page 6 8/14/07, 8/15/07, 8/16/07, and 8/17/07. The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospital's performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to the review and assessment of the patient's care record for compliance of repositioning, the implementation and adherence of the hospital's wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). c. Patient #33's 8/11/07 nursing assessment stated "Skin Breakdown ...Bottom...Protective Ointment Applied." Similar information regarding the area was documented daily in his nursing assessments dated from 8/12/07 to 8/21/07. However, the 8/21/07 "Prevalence Report" included a row for Patient #33 but information related to his pressure ulcers was not included on the grid. Column 18 stated "Reason Patient Not Assessed" and an "x" was placed in the sub-column for "Contraindicated." When asked on 11/9/07 at 2:30 PM, why Patient #33 was considered "Contraindicated" an employee who worked in the PI department stated they did not know why he was contraindicated. The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospital's performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to; the review	BB124		

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BB124	Continued From page 7 and assessment of the patients care record for compliance of repositioning, the implementation and adherence of the hospitals wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). d. The 8/21/07 "Prevalence Report" included a row for Patient #23. In summary, the "Prevalence Report" documented Patient #23 was at risk and had developed a hospital and a unit acquired pressure ulcer. The report documented she had developed a Stage I and a Stage II pressure ulcer and that there was "No Evidence" of "Pressure Ulcer Prevention" measures being used. Further, summary documentation of the 8/21/07 "Prevalence Study" documented a Stage 1 hospital acquired pressure ulcer on her spine. However, the summary did not include documentation of the pressure area on her sacral area. The summary information was not consistent with the "Prevalence Report." Additionally, Patient #23's nursing notes dated 8/16/07 at 1:00 PM documented she had developed "Skin Breakdown...sacrum ...small open area 1inX1/4 in w/surrounding redness. Cream applied." Similar information related to the pressure area on 8/17/07, 8/18/07, 8/19/07, 8/20/07, and 8/21/07. The facility's "Pressure Ulcer Prevalence Report," completed one day each quarter, did not provide sufficient information necessary to adequately assess the hospital's performance (i.e., specific day to day data to identify patient specific quality indicators such as but not limited to; the review and assessment of the patients care record for	BB124		

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BB124	Continued From page 8 compliance of repositioning, the implementation and adherence of the hospitals wound and Braden scale policies, appropriateness, and efficacy of the interventions and other operational aspects of performance that had the potential to lead to improved facility systems for the prevention and care of pressure ulcers). On 11/9/07 at 2:30 PM, a hospital employee who worked in the PI department stated the hospital did retain a day to day cumulative data base of patients that developed pressure ulcers. She confirmed the PI department did not have specific data of patients that included quality indicators that lead to the development of pressure ulcers. She said the PI department did not have a data base of reviewed hospital services and operations aspects of performance that could have been used to assess the processes of care and could have lead to the reduction of the development of pressure ulcers. She said the hospital's PI department did not have a written plan based on cumulative data to reduce the rate of hospital acquired pressure ulcers. The Prevalence study did not lead to documented evidence that the hospital had followed their 3/15/07 "FY08 SARMC Quality and Safety Plan," (on improving their "definitions and data collection tools and processes for quarterly prevalence study" or had defined "standards of nursing assessment and pressure ulcer prevention interventions") and the study was not used in a development of a written plan to reduce the rate of hospital acquired pressure ulcers. Further, the Prevalence study did not document patient specific day to day data to identify patient specific quality indicators (i.e., review and assessment of the patients care record for compliance of repositioning, implementation and adherence to	BB124		

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BB124	Continued From page 9 the hospital's wound and Braden scale policies, and other such operational aspects of performance that could have lead to the development of the pressure ulcers). The facility failed to ensure the pressure ulcer quality improvement system included sufficient information necessary to adequately assess the hospital's services, operations, and the processes of care related to patients' skin integrity. 2. Patient #33 was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. An incident report, dated 8/23/07, documented that on 8/22/07, the "PT [patient] with ¾ in X ¼ in oval skin breakdown on L [left] coccyx area, purple discoloration, and several blisters on R [right] coccyx on 8/22, skin protectant [sic] cream applied and pt. [patient] repositioned on sides. Wound consult ordered. On 8/23 blisters no longer intact and 1in round and 1/4in round stage I skin breakdown present. Wound nurse in to evaluate. Skin protectant [sic] cream placed w/saran wrap to prevent rubbing off." An investigation related to the incident report could not be found. When asked, on 11/8/07 at 9:10 AM, an RN who was the unit manager at the time the patient had developed the pressure ulcer, stated she did not investigate the incident report. On 11/8/07 at 9:30 AM, the DNS stated that incident reports are first given to the unit manager to investigate and then passed on to the PI department to analyze the information and identify reoccurring issues. He said that to the best of his knowledge, the above incident was not investigated.	BB124		

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BB124	Continued From page 10 On 11/9/07 at 2:30 PM, 2 hospital employees who worked in the PI department stated they were unaware of the incident report and confirmed the report was not used to assess the hospital's process of patient care to reduce the frequency of hospital acquired pressure ulcers. The facility failed to ensure all pertinent incident information was investigated and analyzed in an effort to identify and safeguard against reoccurring issues.	BB124		
BB173	16.03.14.310.01 Director of Nursing Services 310. NURSING SERVICE. There shall be an organized nursing department with a plan that delineates authority, responsibility and duties of each category of nursing personnel, and a functional structure for cooperative planning and cooperation. An organizational chart shall be in the nursing service office and in all policy manuals. Job descriptions shall be available and in use which delineate responsibilities, functions or duties, and qualifications for each category of nursing positions. (10-14-88) 01. Director of Nursing Services. The nursing service shall be under the overall direction of a qualified registered nurse with education and experience commensurate with size and complexity of the hospital whose duties are as follows: (10-14-88) a. To organize, coordinate, and evaluate nursing service functions and staff; and (10-14-88) b. To be responsible for development and implementation of policies and procedures as	BB173	Please see response to tag A395 on CMS form 2567 submitted on 12/27/2007.	

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BB173	Continued From page 11 they relate to care of patients; and (10-14-88) c. To select, promote, and terminate nursing staff; and (10-14-88) d. To establish a procedure to insure staff licenses are valid and current. (10-14-88) This Rule is not met as evidenced by: Based on review of hospital policies, record review, and staff interviews, it was determined the Director of Nursing Services failed to ensure that nursing staff had implemented hospitals policies and procedures as they relate to the accepted standards of nursing practices for 8 of 18 patients (#s 23, 24, 25, 33, 46, 56, 57 and 59) whose records were reviewed and documented the patients' had developed hospital acquired pressure ulcers. This resulted in patients not receiving adequate care in the prevention and treatment of pressure ulcers. The findings include: 1. The hospital's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy, revised in 5/06, stated in the "Definition of and Treatment for Pressure Ulcers" section of the policy stated the following: Stage I - "The ulcer appears as defined area of persistent redness in light pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues." Suggested care and treatment of stage 1 pressure ulcers was to use moisturizing creams or protective ointment to affected areas. Stage II - "Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is	BB173		

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BB173	Continued From page 12 superficial and presents clinically as an abrasion, blister, or shallow crater...It is shallow, moist, painful, and pink-red in color and may have superficial yellow slough..." The care and treatment for stage 2 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24 - 48 hours. Stage III - "Full thickness skin loss involving damage to, or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue." The care and treatment for stage 3 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, loosely pack the wound with gauze and wound gel or saline and change the dressings every 24 - 48 hours. Stage IV - "Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon or joint capsule)..." The care and treatment for stage 4 pressure ulcers included: cleanse with normal saline, use skin prep around wound edges, loosely pack the wound with gauze and wound gel or saline and change the dressings every 24 hours. Non-Stageable - "When necrotic tissue is present, a pressure ulcer cannot be accurately staged until the necrotic tissue is removed. Dark purple or bruised areas, over bony prominences, with intact skin may indicate deeper tissue damage."	BB173		

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BB173	Continued From page 13 The "Documentation" section of the policy stated staff were to "Document daily and prn the size, color, character, exudate [sic] of all wounds." The policy further stated "The Braden Scale is a rating scale that will be used by [hospital's name] staff to assess for pressure ulcer risk at admission and daily." The "BRADEN SCALE for Predicting Ulcer Risk" policy revised in 9/06, and again in 11/07, stated "The Braden Scale for predicting Pressure Sore Risk is a tool that allows nurses and other health care providers to score a patient's level for developing pressure ulcers. Patients are assessed for pressure ulcer risk at admission and daily." Some recommended interventions included the following: Low Risk Score 15-18: - Encourage patient to turn and shift position. - Address risk factors. Moderate Risk Score 13-14: - Supplement turning with small shifts in position. One example was to increase turning with a 30 degree foam wedge or pillows. - Provide appropriate pressure reducing support surface. Some examples included specialty mattresses or specialty padded boots. - Certified Wound-Ostomy-Continence Nurse consult. High Risk Score 10-12: - Supplement turning with small shifts in position. - Provide appropriate pressure reducing support surface. - Certified Wound-Ostomy-Continence Nurse consult.	BB173		

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BB173	Continued From page 14 Severe Risk Score less then or equal to 9: 1. Supplement turning with small shifts in position. 2. Provide appropriate pressure reducing support surface. 3. Certified Wound-Ostomy-Continence Nurse consult. The frequency of patient positioning was not addressed in either the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" or the "BRADEN SCALE for Predicting Ulcer Risk" policies. When asked about patient positioning, staff stated the following: - On 11/9/07 at 10:40 AM, a CWOCN confirmed the above policy and procedure and stated it was the hospital's best practice to turn patients at least every 2 hours. - On 11/5/07 at 1:53 PM, a nurse, who was a unit manager, stated patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning. The nurse stated that all patients' positions were to be documented every 2 hours in the EMTEK whether they could self turn or needed assistance with turning. - On 11/5/07 at 2:07 PM, a nurse, who worked at the hospital, stated all patients were to be repositioned every 2 hours if they cannot move or need assistance with repositioning. The nurse also stated that CWOCNs were to be consulted for all patients that had developed or had pressure ulcers prior to their admission. The nurse stated that patients' positioning was to be documented in the EMTEK. - On 11/5/07 at 2:16 PM, a second nurse, who	BB173		

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BB173	Continued From page 15 worked as unit manager, stated all patients were to be repositioned every 2 hours if they could not move or need assistance with repositioning. The nurse also stated CWOCNs were consulted for all patients that had developed or had pressure ulcers prior to admission. The nurse stated that patients' positioning was documented in the EMTEK whether they could self turn or needed assistance with turning. - On 11/5/07 at 2:39 PM, a nurse who worked at the hospital stated, all patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning. - On 11/5/07 at 3:30 PM, the hospital's DNS stated all patients were to be repositioned every 2 hours if they could not move or needed assistance with repositioning. - On 11/6/07 at 9:43 AM, a CWOCN stated all patients that were identified as having a Braden scale score of 13 or less or had pressure ulcers were to be followed by a CWOCN. She stated they were responsible for assessing each patient to identify the patient's individual special needs to help prevent the development or further development of pressure ulcers including obtaining appropriate pressure reducing support surfaces, wound treatment, and staff education. - On 11/8/07 at 10:46 AM, a nurse who worked at the hospital stated that patients were to be turned every 2 hours or more if needed. The nurse stated they rotated patients from lying on their right side, to their back, then to their left side. She stated this was recorded in the "ACTIVITY Position" section of the patient's EMTEK. The facility failed to ensure patients were assisted	BB173		

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BB173	Continued From page 16 to reposition every 2 hours and that the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" and the "BRADEN SCALE for Predicting Ulcer Risk" policy were consistently implemented as follows: * Patient #33 was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. The patient was a 66 year old male that was admitted to the hospital after being found unresponsive in his home. The patient's Braden scale on 8/13/07 was 9 (severe risk: supplement turning with small shifts in position, provide appropriate pressure reducing support surface, Certified Wound-Ostomy-Continence Nurse consult). Patient #33's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 9. Additionally, the "ACTIVITY Position" section of his EMTEK documented that he had not been repositioned every 2 hours or provided supplemental turning with small shifts in position during the following dates and times: - 8/11/07: right side from 10:00 PM to 2:00 AM on 8/12/07. His nursing assessment stated "Skin Breakdown...Bottom...Protective Ointment Applied." - 8/12/07: left side from 2:00 AM until 10:00 AM, supine from 10:00 AM to 2:00 PM and supine from 6:00 PM to 12 midnight. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM, 12:00 PM, 6:00 PM and 8:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...Skin is reddened." His treatment flow sheet listed his Braden score as	BB173		

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BB173	Continued From page 17 11. - 8/13/07: left side from 12 midnight to 4:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...Buttocks are reddened, no skin breakdown noted." His treatment flow sheet listed his Braden score as 9. - 8/14/07: right side from 12:00 AM to 4:00 AM, supine from 4:00 AM to 2:00 PM and on his right side from 2:00 PM to 6:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...Reddened." His treatment flow sheet listed his Braden score as 11. - 8/15/07: right side from 4:00 AM to 12:00 PM. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 10:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...edness [sic] noted skin intact." His treatment flow sheet listed his Braden score as 10. - 8/16/07: right side from 12:00 AM to 8:00 AM and supine from 6:00 PM to 4:00 AM on 8/17/07. His nursing assessment stated "Skin Breakdown...Bottom...No dressing." His treatment flow sheet listed his Braden score as 11. - 8/17/07: supine 6:00 AM to 10:00 AM and supine from 10:00 PM to 8:00 AM on 8/18/07. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM. His 8/17/07 nursing assessment stated "Skin Breakdown...Bottom...less reddenned [sic] than previous day, no open areas noted." His 8/18/07 nursing assessment stated "Skin	BB173		

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BB173	Continued From page 18 Breakdown...Bottom...No dressing. 6-in diameter of redness. Open bleeding area noted." His treatment flow sheet listed his Braden score as 17 on 8/17/07 and as 11 on 8/18/07. The facility failed to ensure Patient #33 was appropriately reposition every 2 hours, that the Braden scale policy interventions were implemented given his continued low scores (supplement turning with small shifts in position, provide appropriate pressure reducing support surface, Certified Wound-Ostomy-Continence Nurse consult) and that appropriate wound care occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24 - 48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Patient #33's medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the progression of his pressure ulcer. The "ACTIVITY Position" section of his EMR documented that he was not positioned appropriately during the following dates and times: - 8/19/07: right side from 4:00 AM to 10:00 AM, supine from 10:00 AM to 10:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...No dressing, open area on R buttocks. Reddened around and on L..." His treatment flow sheet listed his Braden score as 9. - 8/20/07: supine from 2:00 PM to 8:00 PM. His	BB173		

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BB173	Continued From page 19 nursing assessment stated "Skin Breakdown...Bottom...reddened, has two small areas that are open and occasionally bleeding, cleaned well, applied barrier cream." His treatment flow sheet listed his Braden scores as 11 and 9. - 8/21/07: His nursing assessment stated "Skin Breakdown...Bottom...reddened, coccyx, has small opening noted to right buttocks, cleaned well and applied barrier crm [cream]..." Additionally, a CWOCN consult, dated 8/21/07, stated "First step [mattress] obtained for comfort care." His treatment flow sheet listed his Braden score as 11 and 13. - 8/22/07: His nursing assessment stated "Skin Breakdown...Bottom...1in blister and purple discoloration. 3/4in oval stage 1 breakdown." Additionally, an 8/23/07 Incident Report documented that on 8/22/07, the "PT [patient] with ¾ in X ¼ in oval skin breakdown on L [left] coccyx area, purple discoloration, and several blisters on R [right] coccyx on 8/22, skin protectant [sic] cream applied and pt. [patient] repositioned on sides. Wound consult ordered. On 8/23 blisters no longer intact and 1in round and 1/4in round stage I skin breakdown present. Wound nurse in to evaluate. Skin protectant [sic] cream placed w/saran wrap to prevent rubbing off." A Braden score was not documented on his treatment flow sheet. - 8/23/07: left side from 2:00 AM to 8:00 AM. The record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 4:00 AM. His nursing assessment stated "(Skin Breakdown...Rectum...1.5cmx2cm...No dressing Partial thickness skin loss blistered excoriated	BB173		

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BB173	Continued From page 20 1.5cmx2cm. Barrier cream applied...Bottom...No dressing Wound is excoriated inflamed Large blisters have opened and drained...Rectum...3cmx3cm...No dressing Partial thickness skin loss open blister 3cmx3cm.Barrier [sic] cream applied." Additionally, a CWOCN consult, dated 8/23/07, stated "Was not informed on 8/21 that this patient had skin breakdown r/t [related to] being down at home. Has skin breakdown of both buttocks r/t [related to] being done [sic] at home - now outer skin has sloughed and red wound base is seen. Skin protective paste is being applied qid [four times daily]. Left heel has black eschar - dry - no drainage - probably related to how he was laying on the floor at home. Orders written to paint the area with betadine bid [twice daily] and wear prevalon boots at all times." His treatment flow sheet listed his Braden score as 18. The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours and that appropriate wound care occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24 - 48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, a CWOCN was not contacted until 8/21/07 despite his low Braden scores (prior to the 8/23/07 score of 18) and having an open wound since 8/18/07. On 11/9/07 at 10:10 AM, a CWOCN confirmed the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer, per policy, until 8/21/07.	BB173		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB173	Continued From page 21 His medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the CWOCN nurse consult and the continuation of open areas on his buttocks. The "ACTIVITY Position" section of his EMTEK documented that he was not positioned appropriately during the following dates and times: - 8/24/07: His nursing assessment at 12:00 AM stated "Contusion/Hematoma...R [right] Heel...4CMX2CM...Hematoma black no open skin noted bootie and barrier cream applied." His nursing assessment at 8:00 AM stated "Skin Breakdown...Bottom...Skin Breakdown...Rectum...3cmx3cm...Unchanged from documentation, cream applied and plastic wrap...Skin Breakdown...Rectum...1.5cmx2cm...Unchanged from documentation...Contusion/Hematoma...R [right]...Heel...4CMX2CM..." His treatment flow sheet listed his Braden score as 16. - 8/25/07: His nursing assessment stated the areas on his rectum continued to be open and barrier cream and plastic wrap were being used. He also had a reddened area on his buttocks was also being treated with barrier cream and plastic wrap. His PT notes stated he was also using Sage boots and an air mattress. His treatment flow sheet listed his Braden score as 13. - 8/26/07: His nursing assessment stated "Dressing moist reinforced" and the shift summary report stated, "The areas on his bottom are very irritated from the loose stools and bleed slightly during cleaning of them..." His treatment flow sheet listed his Braden score as 10.	BB173		

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	130007	A. BUILDING _____ B. WING _____	11/20/2007

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BB173	Continued From page 22 On 11/7/07 at 1:53 PM, an RN, who was a unit manager on the unit to which the patient was admitted, stated nursing attempted to reposition the patient but he always went back to lying on his back. She also stated the patient was incontinent of stool and urine and was often moist or wet. On 11/5/07 at 2:16 PM, a second nurse, who worked as unit manager on the unit to which the patient was admitted, stated the patient was not able to lay on his sides because it affected his vital signs and his blood pressure would drop and this was why he was not repositioned. - 8/27/07: supine from 6:00 AM to 2:00 PM. His record documented that his linens had been changed at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 10:10 AM. His nursing assessment stated "Skin Breakdown...Bottom...reddened excortiated [sic] bottom and coccyx. Barrier paste and saran wrap applied...Skin Breakdown...Rectum...3cmx3cm...reddened and excoriated barrier paste and saran wrap applied...Skin Breakdown...Rectum...1.5cmx2cm...reddened ans [sic] excoriated barier [sic] paste and saran wrap applied." His treatment flow sheet listed his Braden score as 11. - 8/28/07: supine from 8:00 AM to 12:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 10:00 AM. His nursing assessment at 8:15 AM stated "Skin Breakdown...Bottom...Barrier cream with saran wrap, all the wounds are in a butterfly shape all connected togetherinto [sic] one wound	BB173		

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BB173	Continued From page 23 now...Contusion/Hematoma...R [right] Heel...4CMX2CM)..." His nursing assessment at 10:00 PM stated "Skin Breakdown...Bottom...Pt with Stage II decubitus ulcer on sacral region. Saran Wrap dressing inatct [sic]. No oozing noted..." Additionally, a CWOCN consult, dated 8/28/07 at 11:30 AM, stated "coccyx remains with dark eschar over it open area scattered around on the soft tissue will continue with treatment of protective paste and plastic wrap spoke with nursing and empasized [sic] with nursing importance of turning - right heel plantar posterior was black - soft appears to be resolving blood blister - will continue with betadine to area and prevelon boots..." His treatment flow sheet listed his Braden score as 9, 11, and 15. On 11/9/07 at 10:10 AM, a CWOCN confirmed the above documentation and stated it was the hospital's best practice to turn patients at least every 2 hours. She also confirmed that if a patient's Braden scale was 9 or less, that nursing staff, per policy, should be supplementing turning with small shifts in the patient's position. The facility failed to ensure Patient #33 was appropriately reposition every 2 hours and there was no documented evidence of supplemental turning with small shifts in position, despite the ongoing progression of his pressure ulcers. Additionally, despite the CWOCN's emphasis on the "importance of turning" the "ACTIVITY Position" section of his EMTEK continued to document he was not repositioned every 2 hours during the following dates and times: - 8/29/07: right side from 2:00 PM to 6:00 PM and then supine until 10:00 PM. His record also documented he had a pad change at 2:00 PM. His nursing assessment at 12:41 AM stated "Skin	BB173		

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BB173	Continued From page 24 Breakdown...Bottom...ointment applied, stage 2-3 ulcer bilaterally..." His nursing assessment at 3:30 PM stated "Skin Breakdown...Bottom...reddened to bilateral buttocks, left buttocks has much larger area with redness to outside and some blackness to center of wound, very scanty amount of bleeding occasionally. Repositioning frequently..." His treatment flow sheet listed his Braden score as 15. - 8/30/07: His record also documented he had received a back rub at 8:00 AM and that the Physical Therapist had Patient #33 sit at the edge of the bed at 9:45 AM. His nursing assessment stated "Skin Breakdown...Bottom...Area showing signs of healing. No s/s of infection noted. Area cleansed with peri-wipe, barrier cream applied and covered with plastic wrap...Contusion/Hematoma...R [right] heel...4CMX2CM...Skin remains intact ..." His treatment flow sheet listed his Braden score as 12. - 8/31/07: left side from 6:00 AM to 10:00 AM, on his right side from 10:00 AM to 2:00 PM, and on his right side again from 10:00 PM until 4:00 AM on 9/1/07. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 12:00 PM and that he received a backrub, barrier cream and his linen was changed at 2:00 AM. Additionally, a CWOCN consult, dated 8/31/07 at 3:30 PM, stated "area of dark eschar is getting smaller - red wound visible around perimeter of wound will continue with current treatment plan of skin protective paste and saran wrap..." His treatment flow sheet listed his Braden score as 15.	BB173		

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BB173	Continued From page 25 - 9/1/07: His nursing assessment stated "For wound care see treatment Flowsheet [sic]..." and his heel was floated in AFO boots. However, his treatment flow sheets did not include documentation of his wounds until 9/12/07. His treatment flow sheet listed his Braden score as 14 and 16. The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours and that his records consistently reflected his wound status and interventions. Additionally, the "ACTIVITY Position" section of his EMTEK documented he continued to not be repositioned appropriately during the following dates and times: - 9/2/07: right side from 2:00 PM to 6:00 PM and supine from 6:00 PM to 10:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 4:00 PM and 8:00 PM and that his bed pad was also changed at 8:00 PM. His nursing assessment stated "Coccyx area is notable for full thickness skin breakdown with pink granular tissue, old tissue is black. Area is moist, without s/s of infection, covered with transparent dressing...R heel...4CMX2CM...intact skin has 2x3 cm area with black color. Without drainage or dressing..." His treatment flow sheet listed his Braden score as 15. - 9/3/07: His nursing assessment stated "Bottom...large decubitus noted w/ black eschar...R [right] heel...4CMX2CM...rt [right] heel has eschar..." His treatment flow sheet listed his Braden score as 14 and 19. - 9/4/07: right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist	BB173		

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BB173	Continued From page 26 had Patient #33 sit at the edge of the bed at 1:30 PM. His nursing assessment stated "Bottom...left decubitis with brownish tissue, reddened and open on both cheeks, wound care done with saran wrap replaced..." His nursing assessment at 4:00 PM stated "...Bottom...bilateral ulcerations on buttocks dressing inplace [sic] blackened areas noted wound service following...R [right] heel...4CMX2CM...heels remain off bed et boots inplace [sic] and no pressure is on feet or heels..." His treatment flow sheet listed his Braden score as 13 and 12. - 9/5/07: left side from 6:00 AM to 6:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 11:54 AM and the Occupational Therapist had assisted Patient #33 to shave and comb his hair at 2:00 PM. His nursing assessment stated "Bottom...5cm in diameter blacken circular area with superficial breakdown peripherally...R [right] heel...4CMX2CM...blackened area intact..." His treatment flow sheet listed his Braden score as 13. - 9/6/07: His nursing assessment stated "Bottom...Barrier cream placed per wound care nurse. Black eschar over 2 inch diam [diameter] breakdown area x1 and 1inch diam [diemater] area...R [right] heel...4CMX2CM...black , ½ inch diam. Prevalon boot intact ..." His treatment flow sheet listed his Braden score as 16 and 12. - 9/7/07: His nursing assessment stated "Bottom...Sacral area with area of eschar. Some slight bleeding around edges while cleaning him up. Area of coccyx appears to be healing. Area is pink with granulation...R [right] heel...4CMX2CM...Not observed ..." Additionally, the CWOCN's notes, dated 9/7/07 at 4:50 PM,	BB173		

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BB173	Continued From page 27 stated "...staff instructed on wound care as he just moved to this unit..." His treatment flow sheet listed his Braden score as 17, 16, and 10. - 9/8/07: His nursing assessment stated "Bottom...Pt has very large full thickness breakdown on buttock. 2 areas on the L [left] buttock and 1 on the R. [right] Largest area has necrotic tissue in the center with bleeding granulation tissue surrounding. Cleansed with sterile saline and applied polymen dressing. Other breakdown on the R [right] is smaller butr [sic] still full thickness decub with granulation tissue present. MD notified...R [right] heel...4CMX2CM...has darkpurple [sic] blood blister on the R [right] heel, skin is intact and dry..." His treatment flow sheet listed his Braden score as 12 and 10. - 9/9/07: supine from 6:00 PM to midnight. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 PM and 10:00 PM. His nursing assessment at 8:00 AM stated "Skin Breakdown...Bottom...Dressing with small amount of dried drainage; changed and new polymen applied. Patient has full-thickness breakdown on buttocks; two areas on l [left] and one on R [Right]. The left buttock has black necrotic tissue in center and bleeding granulation tissue surrounding. The right is full-thickness decub with granulation tissue...Contusion/Hematoma ..R [Right] Heel...4cmx2cm...blood blister to R [Right] heel." Additionally, his nursing assessment at 8:00 PM stated "Reddened Skin...Nose...[checked] Dressing, clean, dry, intact..." His treatment flow sheet listed his Braden score as 11 and 12. - 9/10/07: right side from 4:00 AM to 9:00 AM.	BB173		

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BB173	Continued From page 28 His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM. His nursing assessment stated at 8:00 PM "Skin Breakdown...Bottom...Minimal drainage, no dressing present. Large eschar present with reddened and open skin surrounding it. No s/s [signs/symptoms] of infection....Reddened Skin...Nose...Skin reddened. Dressing clean, dry, and intact. No s/s [signs/symptoms] of infection." A Braden score was not listed on his treatment flow sheet. - 9/11/07: left side from 12:00 PM to 12:00 PM on 9/12/07. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 2:00 PM on 9/11/07 and at 8:00 AM and 10:00 AM (during a bed bath) on 9/12/07. His nursing assessment stated "Skin Breakdown... Bottom...reddened open area to coccyx, small area of escar [sic] noted to center of wound...Contusion/Hematoma...R [Right] Heel...4cmx2cm...pt [Patient] also has a very small blister noted to left heel... Reddened Skin...Nose...reddened, very small area that has been open but is healing." His treatment flow sheet listed his Braden score as 14 and 12. - 9/12/07: right side from 12:00 PM to 6:00 PM. His record also documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:08 PM. His nursing assessment stated "Skin Breakdown... Bottom...no dressing, skin barrier applied per wound care orders...Reddened Skin...Nose...[checked] Dressing clean, dry, intact..." His treatment flow sheet listed his Braden score as 15 and 12. - 9/13/07: left side from 12:00 AM to 4:00 AM,	BB173		

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BB173	Continued From page 29 supine from 4:00 AM to 2:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 8:00 AM and 10:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...No drsg. [dressing] area is red and has so [sic] eschar that is dry. Ointment applied...Contusion/Hematoma...R [Right] Heel...4cmx2cm...Prevolen boots on. Small blister to left heel. No s/s [signs/symptoms] of infection...Reddened Skin...Nose...Area to bridge of nose is oozing and breakdown from BIPAP mask. Drsg [dressing] is present." His treatment flow sheet listed his Braden score as 12 and 13. - 9/14/07: right side from 8:00 AM to 12:00 PM, and laying on his left side from 6:00 PM to 10:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 10:00 AM. His nursing assessment stated "Skin Breakdown...Bottom...ointment in place...Contusion/Hematoma...R [Right] Heel...4cmx2cm...ecchymotic purple 3cm diameter blister...Reddened Skin...Nose...Wound is excoriated black with eschar on bridge of nose; no drainage..." A Braden score was not listed on his treatment flow sheet. -9/15/07: supine from 6:00 PM to 10:00 PM. His record documented he had received barrier cream and a bed pad change at 8:00 PM. His nursing assessment stated "Skin Breakdown...Bottom...area has slight bleeding spots on bottom. [sic] center. [sic] of wound is black and necrotice [sic]. Out side [sic] edges of wound appear to be pealing away...Reddened Skin...Nose...Area is scabbed and reddened in the midline." His treatment flow sheet listed his Braden score as 14 and 9.	BB173		

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BB173	Continued From page 30 - 9/16/07: His nursing assessment stated "Skin Breakdown...Bottom...large area on bilateral checks [sic] that are stage 3 ulcer with some areas of bleed. [sic] middle of right butt check [sic] wounds is black and necrotic...Contusion/Hematoma...R [Right] Heel...4cmx2cm...Reddened Skin...Nose...area is scabbed with large wound at the bridge of nose." His treatment flow sheet listed his Braden score as 15. -9/17/07: right side from 4:00 AM to 2:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 12:00 PM. On 9/17/07 at 1:43 PM, the CWOCN documented, "...Wound care physician not yet in but referral was made...Patient is being turned and is on air bed. Will need same cares to continue if transferred..." His treatment flow sheet listed his Braden score as 15 and 13. - 9/18/07: His nursing assessment stated "Skin Breakdown...Bottom...Black escar [sic] noted on left buttock/coccyx area, deep area open on both sides...Contusion/Hematoma...R [Right] Heel...4cmx2cm...Right heel approx 1.5 inchx1 inch black circle, closed...left heel has eraser sized black area...Reddened Skin...Nose...Scabbed area - ointment applied..." His treatment flow sheet listed his Braden score as 15. The facility failed to ensure Patient #33 was appropriately repositioned every 2 hours. Additionally, the wound to his left heel, noted on 9/11/07, was not again documented on until 9/18/07. Further, his EMTEK under the "ACTIVITY Position" documented he continued to	BB173		

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BB173	Continued From page 31 not be repositioned appropriately as follows: - 9/19/07: His nursing assessment stated "Skin Breakdown...Bottom...[checked dressing clean, dry, intact. Breakdown has quarter-sized area of necrotic tissue in center...Contusion/Hematoma...R [Right] Heel...4cmx2cm...blood blister present in 4x2 cm area on heel. Prevalon boots on... Reddened Skin...Nose...scabbed over. Dime-sized. Bacitracin ointment applied." His treatment flow sheet listed his Braden score as 16 and 12. - 9/20/07: His nursing assessment stated "...contacted wound nurse...stated...[physician's name] wound [sic] not be coming to floor and likely to debride wound when transferred to rehab." His treatment flow sheet listed his Braden score as 12. -9/21/07: supine from 8:00 AM to 12:00 PM. His record also documented he had received a bed bath and linen change at 10:15 AM. His CWOCN note stated "Nose is healing well and escar [sic] is resolving. Coccyx ulcer with black escar [sic] resolving, deeper with debridement and base with yellow slough. I conservatively removed and new granular tissue is present. No odor or signs of acute infection. Notified [physician's name] of confusion with who was coming to debride wound and suggested that patient could benefit from debridement. Patient should continue air overlay if DC'd [discharged] to ECF [extended care facility]. Same wound care needed. Could benefit from alginate now in wound base. It now has some depth. I wrote out these reccomendations [sic] and attached to the DC [discharge] orders ..." His treatment flow sheet listed his Braden score as 14.	BB173		

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BB173	Continued From page 32 -9/22/07: left side from 12:00 AM to 8:00 AM and on his right side from 8:00 AM to 4:00 PM. His record documented that the Physical Therapist had Patient #33 sit at the edge of the bed at 12:15 PM. His nursing assessment stated "Wound to coccyx debrided by Wound service. Wound base is covered greater than 50% with thick, yellow slough. Unknown if discharge will take place on Sun or Mon." His treatment flow sheet listed his Braden score as 15 and 14. - 9/23/07: A physician's progress note stated "Surgery I have examined Pt's [patient's] sacral decubitus ulcer. It seems as though another surgeon was initially consulted to evaluate this problem. Currently, my opinion is that the wound looks reasonably clean with granulation noted. I would not be interested in debriding the wound @ this time, as less aggressive measures are working." His treatment flow sheet listed his Braden score as 16. - 9/24/07: His nursing assessment stated "...Coccyx large red to pink open area with no s/s [signs/symptoms] of infection, signs of healing noted, dressing changed per orders...Contusion/Hematoma...R [Right] Heel...4cmx2cm ..No c/o [complaints of] tenderness, heel in bootie and floated...Reddened Skin...Nose...Brown scab noted on bridge of nose, no s/s [signs/symptoms] of infection or drainage noted...Padding placed under BiPAP mask." A CWOCN note stated "Nose eschar continues with no redness - decreasing in size - dry. Right heel eschar is dry - no drainage - to be transferred today..." His treatment flow sheet listed his Braden score as 13. - 9/25/07: His nursing assessment stated "Skin	BB173		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTEI	1055 NORTH CURTIS ROAD BOISE, ID 83706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB173	Continued From page 33 Breakdown...Bottom...Dressing intact, white thick drainage noted at center of wound, edges pink to red with evidence of healing noted...R [right] heel...4cmx2cm..." His treatment flow sheet listed his Braden score as 15. - 9/26/07: His nursing assessment stated "Skin Breakdown...Bottom...Dressing clean, dry, intact. Wound edges pink to red. Small amount of thick white drainage in center of wound. No s/s [signs/symptoms] of infection...R [right] heel...4cmx2cm...Reddened Skin...Nose...No dressing; small scab present, no s/s [signs/symptoms] of infection. Evidence of healing present. Bacitracin ointment applied." A Braden score was not recorded on his treatment flow sheet. - 9/27/07: "Skin Breakdown...Bottom...Not assessed at this time." His treatment flow sheet listed his Braden score as 14. - 9/28/07: Patient #33 was discharged to an Extended Care Facility. When asked about Patient #33's records, the CWOCN stated on 11/9/07 at 10:10 AM, the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer, per policy, until 8/21/07 and she confirmed the EMTEK documentation. Patient #33 was not provided with appropriate and timely care for his pressure wounds. The facility's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" and "BRADEN SCALE for Predicting Ulcer Risk" policies were not implemented. Patient #33's record did not include documentation that he was	BB173		

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BB173	Continued From page 34 consistently reposition every 2 hours with small shifts in position and his records did not consistently reflect his wound status and interventions. The Supervising RN failed to ensure Patient #33's care was appropriately evaluated on an ongoing basis in accordance with accepted standards of nursing practice and hospital policy. * Patient #25 was admitted to the hospital on 8/7/07 and was discharged on 8/17/07. The patient was a 74 year old male who had an aortic valve replacement and coronary artery bypass. His medical record did not include documentation that he was provided with interventions as outlined in the "BRADEN SCALE for Predicting Ulcer Risk" policy and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy as follows: - 8/7/07: His treatment flow sheet listed his Braden score as 22 prior to surgery and 14 after surgery. - 8/8/07: His treatment flow sheet listed his Braden score as 12 and 15. - 8/9/07: The "ACTIVITY Position" section of his EMTEK documented no evidence that he had been repositioned every 2 hours. The EMTEK documented that he was supine from 4:00 AM to 8:00 AM and from 10:00 AM to 4:00 PM. His record documented supplemental repositioning (i.e., change in the angle of the head of the bed, etc.) had occurred at 6:00 AM, 11:00 AM and 12:00 PM and that a rotation mattress was initiated at 11:00 AM. His treatment flow sheet listed his Braden score as 14 and 17. His nursing notes stated he had a skin impairment of	BB173		

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BB173	Continued From page 35 reddened skin on his left buttocks due to pressure. The notes documented at 8:00 AM, "1x2 cm purple pressure sore, skin intact, protective barrier cream applied." His nursing notes also documented he had a skin impairment of reddened skin on his right posterior upper thigh due to pressure. The notes documented at 8:00 AM, "No dressing, 1x4 purple pressure sore, skin intact, protective barrier cream applied." His nursing assessment at 6:25 PM stated "...Pressure sores on back side, intact, change out bed to specialty one w/rotation feature..." - 8/10/07: His treatment flow sheet listed his Braden score as 10. His nursing notes at 8:00 AM stated "left buttocks...Skin intact but reddened" and "upper thigh...Skin intact." - 8/11/07: His treatment flow sheet listed his Braden score as 12. His 8:00 AM nursing notes stated "left buttocks...Skin intact but reddened" and "upper thigh...2 inch area of dark red skin, skin intact." - 8/12/07: His treatment flow sheet listed his Braden score as 15. His 7:30 AM nursing notes documented "left buttocks...Approximately the size of a pencil eraser, opened with slight bleeding noted" and "upper thigh...irregular oval shaped reddened pressure area noted. Skin intact. Approx ½ inch in length." - 8/13/07: His treatment flow sheet listed his Braden score as 18. His 8:00 AM, nursing notes documented "left buttocks...area is covered with barrier cream. Area is beginning to heal" and "upper thigh...no dressing, covered with barrier cream." Additionally, at 8:00 PM, his nursing notes documented he had a skin integrity impairment of skin breakdown on the back of his	BB173		

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BB173	Continued From page 36 head. The notes stated "Area reddish purple colored approx size of quarter, Pt [patient] using head doughnut." Patient #25's record did not include documentation that staff covered the open wound on his left buttocks with a foam or non-adherent dressing every 24 to 48 hours per the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Additionally, there was no documented evidence that the CWOCN was consulted per the "BRADEN SCALE for Predicting Ulcer Risk" policy due to his low Braden scores (i.e., 13 or below as documented on 8/8, 8/10, and 8/11/07). His medical records further documented the following: - 8/14/07: His treatment flow sheet listed his Braden score as 17. His 8:00 AM, nursing notes stated "left buttocks...Reddened and wound is open and appears to be in early stages of healing...barrier applied" and "upper thigh...Reddened/purplish in color barrier applied. Skin appears to be intact." Additionally, the notes documented "back of head...Remains reddish/purple in color. Skin is intact. Donut [sic] remains in place." - 8/15/07: His treatment flow sheet listed his Braden score as 17 and 19. His 8:00 AM nursing notes stated "left buttocks...No dressing, remains reddened, barrier applied" and "upper thigh...No dressing." Additionally, his nursing notes documented "back of head...Remains intact, purplish in color." - 8/16/07: His treatment flow sheet listed his Braden score as 20. His 8:00 AM nursing notes stated "left buttocks...No dressing, skin intact, no	BB173		

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BB173	Continued From page 37 redness" and "upper thigh...No dressing, surrounding skin red, wound yellow, no drainage. Skin barrier ointment prn." Additionally, the notes stated "back of head...No dressing, wound scabbed over, no drainage." - 8/17/07: The "ACTIVITY Position" section of the Treatment Flowsheet documented Patient #25 was sitting in a chair from 4:00 AM until 6:00 PM. Documentation the patient was repositioned every 2 hours was not present in the patient's record. The notes documented he walked 140 feet at 12:00 PM and 280 feet at 4:00 PM. A Braden score was not listed on his treatment flow sheet. His 8:00 AM nursing notes documented "upper thigh...scabbed area approximately 3 cm diameter; no s/s [signs or symptoms] infection." Despite developing no less than 3 pressure ulcers, Patient #25's medical records did not include documented evidence that the CWOCN was consulted. On 11/9/07 at 9:40 AM, a CWOCN confirmed the CWOCN department was not consulted by nursing staff about Patient #25's pressure ulcers. Patient #25 was not provided with appropriate and timely care for his pressure wounds. The facility's "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" and "BRADEN SCALE for Predicting Ulcer Risk" policies were not implemented in response to Patient #25's Braden scores and his development of pressure ulcers. Further, Patient #25's record did not include documentation that he was consistently reposition every 2 hours with small shifts in position. The Supervising RN failed to ensure Patient #25's care was appropriately evaluated on an ongoing basis in accordance	BB173		

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BB173	Continued From page 38 with accepted standards of nursing practice and hospital policy. * Patient #24 was admitted to the hospital on 8/2/07 and was discharged on 8/23/07. The patient was a 80 year old male who had a history of underlying coagulopathy related to alcoholic hepatitis. At the time of his admission, he had a Braden scale score of 14 (Moderate Risk Score, supplement turning with small shifts in position such as increased turning with a 30 degree foam wedge or pillows, provide appropriate pressure reducing support surface such as a specialty mattresses or specialty padded boots). Patient #24's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. Additionally, his medical record documented the following: - 8/9/07: At 8:00 AM the "Integumentary/Skin" section of his nursing notes documented "Reddened Skin...Buttocks...skin is red, blanches, barrier cream applied, instructed pt [patient] to turn to his side as much as possible." - 8/12/07: At 4:30 PM the "Integumentary/Skin" section of his nursing notes documented "Reddened Skin...Buttocks...Reddened, position shifted." At 8:00 PM the notes documented "reddened area on coccyx placed on left side encouraged to stay if possible." At 10:00 PM the notes stated "placed on left side but changes positions" and at 3:00 AM the notes stated "assisted to left side pillows placed to keep of [sic] coccyx area." - 8/13/07: At 8:00 AM the "Integumentary/Skin" section of his nursing notes documented	BB173		

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BB173	Continued From page 39 "reddened area noted buttocks area with skin breakdown, no drainage." - 8/14/07: At 8:00 PM the "Integumentary/Skin" section of his nursing notes documented "coccyx is reddedend [sic]. No s/s [signs/symptoms] of breakdown." - 8/15/07: At 12:00 AM the "Integumentary/Skin" section of his nursing notes documented "Coccyx is red but intact. Pt [patient] will not lie on his sides so is on his back all the time." At 8:00 AM the notes documented "Coccyz [sic] is red, dry and intact. Pt. [patient] refuses to lie on his sides." - 8/21/07: At 11:18 AM the "Integumentary/Skin" section of his nursing notes documented "Pt has 2 small areas of breakdown on coccyx. Wound care nurse aware. Airbed and xenaderm ordered." At 4:00 PM the notes documented "Two small areas of break down. Xenaderm applied and pt [patient] turned on left side." Additionally, the 8/21/07 "Prevalence Report" documented Patient #24 was at risk and had developed a unit acquired, stage 2 pressure ulcer on his buttocks. However, there was "No Evidence" of "Pressure Ulcer Prevention" measures being used beyond nutritional support according to the report. His nursing assessment further stated at 3:30 PM an air bed was initiated, per suggestion of the 8/21/07 prevalence study and a CWOCN note at 7:45AM stated Xenaderm ointment was to be used twice daily and as needed and the patient was to be assisted or reminded to turn every two hours. - 8/22/07: At 12:00 AM the "Integumentary/Skin" section of his nursing notes documented "Breakdownon [sic] Right bottock [sic], dime size,	BB173		

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BB173	Continued From page 40 blanches at 3 seconds, pink and skin is broken at surface. Left buttock is pink and blanches well, skin intact, Xenoderm applied to both sites." At 8:00 AM the notes stated "Small open area on right coccyx. Redness over several inch area, right and left coccyx. Xenaderm being used." - 8/23/07: Patient #24 was discharged from the hospital. Patient #24's record did not contain documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 14. He was not provided with an appropriate pressure reducing support surface as per policy until 8/21/07. On 11/9/07 at 9:10 AM, a CWOCN nurse confirmed the CWOCN department was not consulted by the nursing staff about the patient's pressure ulcer until 8/21/07, the day of the prevalence study. The nurse also confirmed the above documentation. The Supervising RN failed to ensure Patient #24 received appropriate preventative care which was consistent with the Braden scale policy interventions. * Patient #23 was admitted to the hospital on 8/16/07 and was discharged on 8/23/07. The patient was an 87 year old female who had a ground level fall and had a history of degenerative joint disease of the spine and hip. She also had a history of diabetes with chronic renal insufficiency. Her medical record documented she did not receive wound care in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy as follows:	BB173		

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BB173	Continued From page 41 - 8/16/07: At 1:00 PM EMTEK notes documented "Skin Breakdown...sacrum...small open area 1inX1/4 in w/surrounding redness. Cream applied." - 8/17/07: At 8:00 PM EMTEK notes documented barrier cream was applied. - 8/18/07: At 8:00 PM EMTEK notes documented "Skin Breakdown...sacrum...Red with no drainage, barrier applied no Dressing." - 8/19/07: At 8:00 AM EMTEK notes documented no breakdown noted. However, EMTEK notes at 8:00 PM documented "Skin Breakdown...sacrum...Healing without s/s [signs/symptoms] of infection." - 8/20/07: At 8:00 AM EMTEK notes documented "Skin breakdown...sacrum... reddened, skin intact." - 8/21/07: At 8:00 AM EMTEK notes documented "skin breakdown...sacrum...blanchable half dollar sized red area on left upper buttock." Additionally, the hospital's 8/21/07 "Prevalence Report" documented Patient #23 was at risk and had developed a hospital and a unit acquired pressure ulcer. The report documented she had developed a stage 1 and a stage 2 pressure ulcer and that there was "No Evidence" of "Pressure Ulcer Prevention" measures being used. However, summary documentation of the 8/21/07 "Prevalence Study" documented a stage 1 hospital acquired pressure ulcer on her spine. However, the summary did not include documentation of the pressure area on her sacral area.	BB173		

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BB173	Continued From page 42 - 8/22/07: At 8:00 PM EMTEK notes documented "Skin breakdown...sacrum...stage 2 cocyx [sic] area, open to air, no drainage." - 8/23/07: Patient #23 was discharged. Patient #23's record did not contain consistent documentation related to her skin integrity. Additionally, there was no documented evidence that nursing staff followed the hospital's policy in caring for Patient #23's stage 2 pressure ulcer (cleansing with normal saline, using skin prep, applying barrier cream twice daily, and covering with a foam or non-adherent dressing) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Further, there was no documented evidence that the CWOCN Nurse was consulted regarding the open wound. On 11/9/07 at 9:30 A.M., a CWOCN nurse confirmed the CWOCN department was not consulted by nursing staff about the patient's pressure ulcer. The Supervising RN failed to ensure Patient #23 received appropriate care which was consistent with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. * Patient #57 was admitted to the hospital on 9/16/07 and was discharged on 10/2/07. The patient was a 67 year old female who had a history of amyloidosis and end stage renal disease managed with peritoneal dialysis. Her medical record did not include documentation that she was provided with interventions as outlined in the "BRADEN SCALE for Predicting	BB173		

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BB173	Continued From page 43 Ulcer Risk" policy and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy as follows: The "Integumentary/Skin" section of her nursing assessments, dated 9/16/07 to 9/22/07, documented her skin was warm, dry and of normal color. Her Braden score for 9/20/07 was 19 and her 9/21/07 Braden scores were 19 and 18. Her record documented the following: - 9/22/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated "...Skin Breakdown ...buttocks...Area is reddened. Pea sized scabbed area to coccyx. No s/s [signs/symptoms] of infection noted. Will oreder [sic] wound care consult." - 9/23/07: Her treatment flow sheet listed her Braden score as 16. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM "...Skin Breakdown...buttocks...Buttocks is reddened with dime sized scabbed area to coccyx. No s/s [signs/symptoms] of infection " The "Integumentary/Skin " section of her nursing assessment stated at 8:00 PM "...Reddened Skin...R [right] and L [left] heels...Reddened, skin intact on heels." - 9/24/07: Her treatment flow sheet listed her Braden score as 16. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...Skin around scrape is inflamed, center of wound is yellow/white....Reddened Skin...R [right] and L [left] heels...Skin on heels is red but blanches." A CWOCN note at 1:43 PM stated "stage III of buttocks - has open red and yellow slough areas	BB173		

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BB173	Continued From page 44 of bilateral buttocks and coccyx area. 6X6 cm - no depth to it - patient can turn self. Has sitter. Criticaid applied to the area - orders written to apply tid [three times daily] and prn [as needed]. Turn side to side every 2 hours..." - 9/25/07: Her treatment flow sheet listed her Braden score as 14. The "Integumentary/Skin" section of her nursing assessment stated at 9:00 AM, "...Skin Breakdown...buttocks... No dressing, stage II pressure ulcer, treating with soap and water cleanse and skin protectant cream..." The assessment also stated "...Reddened Skin...R [right] and L [left] heels...No dressing, skin is red, slightly boggy, no signs of further breakdown..." - 9/26/07: Her treatment flow sheet listed her Braden score as 16 and 12. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...Buttocks is red. Two areas of yellow. Wound care to see." The assessment also stated "...Reddened Skin...R [right] and L [left] heels...red, will elevate..." At 4:00 PM, the "Integumentary/Skin" section of her nursing assessment stated "...Reddened Skin...R [right] and L [left] heels...Slightly reddened. Will float heels." Additionally, a CWOCN note, dated 9/26/07 at 5:30 PM, stated "pt [patient] placed on first step mattress. She is unableto [sic] attain a position of comfort on standard hosp [hospital] mattress per staff RN..." - 9/27/07: Her treatment flow sheet listed her Braden score as 14 and 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks... Area reddened, no s/s [signs/symptoms] infection..." The assessment also stated "...Reddened Skin...R [right] and L	BB173		

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BB173	Continued From page 45 [left] heels...Area reddened, no s/s [signs/symptoms] breakdown, heels elevated..." At 8:00 PM, the "Integumentary/Skin" section of her nursing assessment stated"...Skin Breakdown...buttocks...Skin is red with open area with little to no drainage. Wound cleaned and treated with topical cream..." The assessment also stated"...Reddened Skin...R [right] and L [left] heels...Skin remains red, ted hose replaced..." - 9/28/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 AM, "...Skin Breakdown...buttocks...reddened area with yellow center noted to coccyx, area cleansed and ointment applied..." The assessment also stated "...Reddened Skin...R [right] and L [left] heels...reddened..." - 9/29/07: Her treatment flow sheet listed her Braden score as 17 and 14. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 PM, "...Skin Breakdown...buttocks...skin is red with little to no drainage from open area." - 9/30/07: Her treatment flow sheet listed her Braden score as 17. The "Integumentary/Skin" section of her nursing assessment stated at 8:00 PM, "...Skin Breakdown...buttocks...Area reddened with yellow noted to center, area cleaned and topical cream applied..." The assessment also stated "..Reddened Skin...R [right] and L [left] heels...reddened, elevated off bed..." - 10/1/07: Her treatment flow sheet listed her Braden score as 18. The "Integumentary/Skin" section of her nursing assessment stated at 8:00	BB173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130007	A. BUILDING _____ B. WING _____	11/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALPHONSUS REGIONAL MEDICAL CENTEI	1055 NORTH CURTIS ROAD BOISE, ID 83706

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BB173	Continued From page 46 PM, "...Skin Breakdown ..buttocks...[checked] Dressing clean, dry, intact..." The assessment also stated "...Reddened Skin...R [right] and L [left] heels...reddened..." Additionally, a CWOCN note at 1:57 PM stated "Patient with open skin breakdown of the buttocks - yellow slough and red open areas. - applied criticaid with antifungal to the area - covered with saran wrap to keep it on the skin..." - 10/2/07: Patient #57 was discharged from the hospital. Despite documentation that a wound consult was to be ordered on 9/22/07, Patient #57 was not seen by the CWOCN until 9/24/07. In the interim, the patient's EMTEK did not document nursing had followed hospital polices and cleansed the pressure ulcer with normal saline, used skin prep around wound edges, loosely packed the wound with gauze and wound gel or saline and changed the dressings every 24 - 48 hours. The Supervising RN failed to ensure Patient #57 received appropriate care which was consistent with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. * Patient #59 was admitted to the hospital on 10/29/07 and discharged on 11/5/07. The patient's History and Physical, dictated at 4:35 PM on 10/29/07, stated the patient was a 94 year old female with a history of coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, moderate dementia, status post pacemaker, and a history of TIA's. She presented to the ED and was admitted due to acute shortness of breath. The history and physical stated Patient #59 also had	BB173		

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BB173	Continued From page 47 recent admissions to the hospital in August and September for supposed CHF exacerbations. It also noted the patient's right leg was bandaged due to a previous wound on the right shin. A Treatment Flowsheet in the patient's record documented a Braden scale score of 13 at 6:00 PM on 10/29/07. The patient's EMTEK under the ACTIVITY Position section did not contain documented evidence the patient had been repositioned every 2 hours or was provided supplemental turning with small shifts in position during the following dates and times: - 10/29/07: supine from 5:45 PM to 10:00 PM and remained supine from being repositioned at 10:00 PM until 10/30/07 at 6:00 AM. At 6:00 PM an RN documented in the Assessments/Notes section of the patient's record "Integrity Impairment (Skin Breakdown),, R Lower Calf): Dressing CDI (clean, dry, intact). Not assessed at this time." RN documentation in the same section of the patient's record at 8:00 PM stated "Integrity Impairment (Skin Breakdown),, R Lower Calf): Dressing clean dry intact." - 10/30/07: supine from 6:00 AM to 2:00 PM. An 8:00 AM RN nursing note stated the bandage was removed from the wound on the patient's right calf to find green ointment in the wound. No further information regarding the wound was documented by the RN. Also at 8:00 AM the patient's Treatment Flowsheet documented a Braden Scale score of 16. A CWOCN nursing note, at 2:00 PM stated "patient known to service from previous hospitalization - has an open wound on back of left calf - spoke with center for wound healing and hyperbaric medicine state that the treatment plan was a wound VAC with unna	BB173		

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BB173	Continued From page 48 boot - when dressing removed panafill was in place on a [sic] exudry - spoke with nurse at (care center patient was admitted from) states that the wound VAC was stopped because of pain and orders were obtain [sic], they believed, from their resident physician - will place wound gel on patient at this time with with [sic] guaze dressing - and allevyn foam- wrap with kerlix." - 10/30/07: as sitting in a chair 4:00 PM to 8:00 PM. Hygiene activities and a linen change were noted on the patient's Treatment Flowsheet at 4:00 PM. An RN nursing note documented at 8:00 PM that the dressing on Patient #59's calf wound was clean, dry, and intact. - 10/31/07: supine from 11:00 AM to 2:02 PM, at which time a PT assessment was completed and on the right from 8:00 PM to 12:00 AM 11/1/07. On 10/31/07 at 12:00 AM an RN nursing note stated Patient #59's gown and bedding were wet from a leak in her foley catheter. At 8:00 AM an LPN nursing note indicated the dressing on the patient's calf wound was clean, dry, and intact. A Braden Scale score of 16 was also documented in the Treatment Flowsheet at the same time. An LPN documented an assessment of Patient #59's skin integrity at 5:30 PM. The assessment included a new pressure sore "...Nickel sized purple, and reddened area to buttocks, skin break down. Pt. turn [sic] off of buttocks and advise [sic] to stay off of her buttocks. Skin is intact and no s/s of infection noted. Pt. will be turned every 2 hours." The skin breakdown on the patient's buttocks was also noted by an LPN in a nursing note at 7:28 PM and an RN nursing note at 8:00 PM. The only documentation of the status (size, shape) of Patient #59's calf wound was found in	BB173		

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BB173	Continued From page 49 an LPN nursing note on 10/31/07 at 3:00 PM. The note stated "Wound is larger than a silver dollar in size, no s/s (signs/symptoms) of infection noted with some bloody, serious drainage on the old dressing." - 11/1/07: supine from 12:00 AM to 6:00 AM and supine from 12:00 PM to 2:45 PM and again from 10:00 PM to 8:00 AM on 11/2/07. An RN nursing note at 10:05 PM indicated the skin breakdown on the patient's calf had a dressing that was clean, dry, and intact and the skin breakdown on her buttocks was described as "Area reddened. No sign of open skin." A PT note at 2:45 PM stated the patient refused PT in the morning due to fatigue, but participated in the afternoon. The PT note began by stating "Pt supine ..." An RN note at 8:00 PM stated the same for the calf wound and stated the buttocks wound had no dressing and was dry and red. A Braden Scale score of 15 was also documented on the patient's Treatment Flowsheet at 8:00 PM. - 11/2/07: supine 8:00 PM to 8:00 AM 11/3/07. At 9:30 AM on 11/2/07 the CWOCN nurse documented "wound on leg is has [sic] remained same possible a little improved with the wound gel - lower leg with edema - patient has loose cough and is still not ready for compression. BUTTOCKS patient has area on left buttocks near gluteal cleft near coccyx that is deep purple that remains intact - will start xenaderm and place patient on 1st step mattress on area." The mattress overlay was initiated at 10:00 AM 11/2/07. PT notes at 11:23 AM and 4:00 PM on 11/2/07 stated Patient #59 refused therapy due to fatigue. At 8:00 PM, an RN nursing note stated the dressing on the calf wound was clean, dry, and intact and that the wound on the buttocks was not assessed at that time. The patient	BB173		

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BB173	Continued From page 50 refused repositioning at 8:00 PM and at 12:00 AM, 4:00 AM, and 6:00 AM on 11/3/07. Patient refusal to reposition was not documented was a reason for the lack of position change between these times. The Treatment Flowsheet documented a linen change at 4:00 AM on 11/3/07, however, the patient refused a position change. - 11/3/07: supine at 12:00 PM and there was no further documentation of a different position until 2:00 PM on 11/4/07. A Braden Scale score of 14 was documented, at 8:00 AM and 8:00 PM on 11/3/07, on the Treatment Flowsheet section of the patient's record. PT documentation at 3:54 PM indicated the patient refused AM and PM PT due to fatigue. - 11/4/07: left side at 4:00 PM and there was no further documentation of a different position until 12:00 AM on 11/5/07. A Braden Scale score of 11 was documented on the patient's Treatment Flowsheet at 8:00 AM. A nursing note at the same time documented the calf wound as having a clean, dry, and intact dressing and the buttocks wound as having redness and xenaderm applied. At 8:00 PM a nursing note documented the dressing on the calf wound was changed and the buttocks wound described as reddened and xenaderm applied. The one PT note documented for the day at 2 PM stated the patient declined PT due to fatigue and that the patient had thoracentesis earlier in the day. - 11/5/07: A Braden Scale score of 10 was documented at 8:00 AM. A PT note at 9:30 AM stated Patient #59 participated in PT at that time. Patient #59 was discharged to a nursing facility at 4:15 PM with comfort measures in place.	BB173		

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BB173	Continued From page 51 On 11/9/07 at 10:40 AM, a CWOCN nurse confirmed the above documentation and stated it was the hospital's best practice to turn patients at least every 2 hours. The hospital failed to ensure Patient #59 was provided with services necessary to prevent skin breakdown and that the status of her wounds was consistently documented to monitor healing or lack thereof. Note: B173 continued at B9999.	BB173		

IDAHO DEPARTMENT OF HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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January 10, 2008

Sandra Bruce
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, Idaho 83706

Provider #130007

Dear Ms. Bruce:

On **November 20, 2007**, a Complaint Investigation was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003245

Allegation #1: A patient's left femur was fractured on 10/5 or 10/7/07 when staff turned the patient.

Findings: An unannounced visit was made to the hospital on 11/5/07. Ten clinical records were reviewed of patients hospitalized during the time of the alleged incident. Additionally, staff were interviewed.

One patient's medical record documented she was admitted to the hospital on 10/3/07 for pneumonia and discharged on 10/15/07. The record contained a report from the ambulance that transported the patient from her residence to the hospital. The report, dated 10/3/07, documented the patient reported pain in her "left ankle and left hip from an injury that occurred approx 1 week ago when a home health aide accidentally pulled her leg in the wrong direction." A hospital admission history and physical, dated 10/3/07, documented the patient complained of tenderness in her left ankle.

Physician's progress notes documented the following:

10/6/07 at 8:30 AM: "TTP (tender to palpation) in L (left) ankle, x-ray negative ankle fx (fracture), possible stress fracture 3rd and 4th metatarsal (part of the foot)."
10/7/07 at 9:45 AM: "c/o (complained of) L knee pain" and "L knee tender to movement...pain with flexion..."
10/11/07 at 8:15 AM: patient complained of increased pain to "legs, hips."
10/13/07 at 11:00 AM: "still has knee pain"

Physician's progress notes did not contain documentation of a fracture during her stay.

Nursing notes documented the following:

10/7/07 at 8:00 AM: the patient's pain is "primarily to her shoulders and to her left foot and knee."
10/7/07 at 10:00 PM: "calls out in pain when any of her extremities are moved... no pain at rest."
10/8/07 at 10:00 PM: "complains of pain in her lower legs."
10/10/07 at 10:00 PM: complained of "aching pain to left knee."
10/11/07 at 10:00 PM: did not allow RN to assess left heel as patient "states it hurts from a fracture she sustained."
10/12/07 at 8:00 AM: complained of left hip and knee pain. "Pain rated 2/10, aching."
10/14/07 at 10:00 PM: patient complaining of aching pain "7/10" to left knee

Nursing notes did not contain documentation the patient complained that her leg had been fractured or injured while she was hospitalized.

Physical Therapy notes included the following documentation:

10/8/07 at 1:30 PM - complained right "shoulder dislocated"
10/9/07 at 1:30 PM - "states left leg is broken and to leave it be"

Physical Therapy notes did not contain documentation that the patient complained that her leg had been fractured or injured while she was hospitalized.

On 11/7/07 at 2:40 PM, an RN who knew the patient personally and worked with her on discharge planning was interviewed. She stated the patient complained of pain in numerous areas but did not state her leg had been fractured. She stated the patient frequently refused to be moved and didn't want to be touched.

On 11/7/07 at 3:00 PM, an RN who was a charge nurse was interviewed. She stated she knew the patient personally and also provided care for her was interviewed.

She stated they used a "lift" to raise the patient to clean her and change the bedding. She stated the patient did not complain that her leg had been fractured. Additionally, she stated the patient's pain level remained constant throughout her hospitalization.

On 11/8/07 at 8:00 AM, an RN who cared for the patient while she was on the telemetry unit was interviewed. He stated the patient did not complain that her leg had been fractured when turned at the hospital. He stated they used a "lift" to elevate the patient to clean her and change the bedding. He said she would complain of pain with any movement and there was no change in her pain level while she was on the telemetry unit.

On 11/8/07 at 8:10 AM, a Physical Therapist who provided care to the patient while she was hospitalized was interviewed. She confirmed she documented that the patient stated her leg was broken and to leave it alone. She said the way the patient told her about the leg led her to believe it had happened in the past. She stated the patient did not tell her that her leg had been fractured or injured while she was in the hospital.

Unsubstantiated. Although the patient's leg may have been fractured when she was hospitalized, there was no evidence to validate the complaint. Additionally, the patient had complained of an injured left leg prior to her admission to the hospital.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The call light, which was activated by a blow straw, was placed out of the reach of a bed bound patient .

Findings: Ten clinical records were reviewed. All records contained "Treatment Flow" sheets that documented the type and accessibility of call lights provided to patients during hospitalization.

One patient's record documented she was provided a standard call light from 10/3 to 10/7/07 at 8:00 PM when she was given a call light that was activated with a blow straw. She continued to use the blow straw until her discharge on 10/15/07. "Treatment Flow" sheets documented the call light was accessible by the patient during her hospitalization.

On 11/5 and 11/6/07 a tour of the hospital was conducted and patient's were interviewed. Patient's interviewed had no complaints about call lights not being place within their reach. During the tour it was noted that all patient rooms had call lights accessible to patients either on the bed rail or a hand held model attached to the wall.

On 11/7/07 at 3:00 PM, an RN who was a charge nurse and had provided care to the

She stated if the call light was out of reach for the patient she was unaware of it. She stated the patient did not complain to her that she had been unable to alert staff.

On 11/8/07 at 8:00 AM, an RN who had provided care to the patient stated he was unaware of anytime the patient's call light was not accessible. He said the patient did not complain to him that she had been unable to access her call light.

Unsubstantiated. Although the allegation may have occurred, it could not be validated during the survey.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A patient who requested not to receive morphine was given the medication on two occasions.

Findings: One patient's record documented a physician's order for PRN (as needed) morphine. The patient's record documented nursing staff offered her pain medication, which included morphine, when she complained of pain. The record also documented she was offered pain medication prior to staff providing care which might cause her discomfort. Nursing notes documented that there were times the patient was offered morphine for pain and she refused. Additionally, nursing notes also documented there were times the patient took morphine for pain. Review of the patient's MAR (medication administration record) did not document a time when the patient was given pain medication that she had refused.

Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation. There was no evidence that the patient was unable to refuse medications that were offered.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A patient who thought their femur was fractured during their hospitalization requested an x-ray from physicians and nurses but they refused.

Findings: One patient's medical record documented she was admitted to the hospital on 10/3/07 for pneumonia and was discharged on 10/15/07. Physician's progress notes, dated 10/3 through 10/15/07 did not contain documentation that the patient requested an x-ray of her left leg. Additionally, nursing notes, dated 10/3 through 10/15/07, did not contain documentation that the patient wanted an x-ray of her left leg.

On 11/7/07 at 2:40 PM, an RN who knew the patient personally and worked with her on discharge planning was interviewed.

She stated the patient did not tell her that she thought her leg was fractured or complained that she had been injured while hospitalized. She said that patient did not tell her that she wanted an x-ray of her leg.

On 11/7/07 at 3:00 PM, an RN who was a charge nurse, knew the patient personally and provided care for her was interviewed. She stated the patient did not complain that her leg had been fractured. Additionally, she stated the patient did not request an x-ray of her leg that she was aware of.

On 11/8/07 at 8:00 AM, an RN who cared for the patient while she was on the telemetry unit was interviewed. He stated the patient did not complain that her leg had been broken when turned at the hospital. Additionally, he stated the patient did not request an x-ray of her leg that he was aware of.

Unsubstantiated. Although the patient may have requested an x-ray of her left leg there was no documentation contained in the record, or confirmed by interview that substantiated the allegation.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Sylvia Creswell for

RAE JEAN MCPHILLIPS
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

RJM/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 30, 2008

Sandra Bruce
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, Idaho 83706

Dear Ms. Bruce:

On **November 20, 2007**, a Complaint Investigation was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003216

Allegation: Patients were not repositioned at the hospital in an effort to prevent the pressure ulcers and patients subsequently developed pressure ulcers.

Findings: An unannounced visit was made to the hospital on 11/5/07. 18 clinical records were reviewed of patients who had developed hospital acquired pressure ulcers during their stay at the hospital. The hospital policies and quality improvement program was also reviewed. Additionally, staff were interviewed.

One patient's record revealed the patient was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. The patient was a 66 year old male that was admitted to the hospital after being found unresponsive in his home. The patient's Braden scale on 8/13/07 was 9 (severe risk: supplement turning with small shifts in position, provide appropriate pressure reducing support surface, Certified Wound-Ostomy-Continence Nurse consult). The patient's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 9. Additionally, the "ACTIVITY Position" section of his EMTEK documented that he had not been repositioned every 2 hours or provided supplemental turning with small shifts in position.

It was further discovered that appropriate wound care had not occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24 - 48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Lastly, a CWOCN was not contacted until 8/21/07 despite his low Braden scores (prior to the 8/23/07 score of 18) and having an open wound since 8/18/07. His medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the CWOCN nurse consult on 8/21/07 at 11:30 AM.

After the investigation, it was determined the hospital failed to provide adequate care for 8 of 18 patients on an ongoing basis in accordance with accepted standards of nursing practices and hospital's policies. The hospital's nursing staff failed to follow the hospital's "BRADEN SCALE for Predicting Ulcer Risk" policy interventions, and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy and interventions. The cumulative effect of these negative facility practices resulted in harm to patients, and the potential for serious harm or death to occur.

Deficiencies were cited at 42 CFR 482.23 Condition of Participation: Nursing services for the failure of the hospital to ensure that nursing staff had adequately cared for patients on an ongoing basis in accordance with accepted standards of nursing practices and hospital's policies. The hospital provided a plan of correction. A follow up survey was completed and the hospital was found in compliance with all Conditions of Participation.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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January 30, 2008

Sandra Bruce
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, Idaho 83706

Dear Ms. Bruce:

On **November 20, 2007**, a Complaint Investigation was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003216

Allegation: Patients were not repositioned at the hospital in an effort to prevent the pressure ulcers and patients subsequently developed pressure ulcers.

Findings: An unannounced visit was made to the hospital on 11/5/07. 18 clinical records were reviewed of patients who had developed hospital acquired pressure ulcers during their stay at the hospital. The hospital policies and quality improvement program was also reviewed. Additionally, staff were interviewed.

One patient's record revealed the patient was admitted to the hospital on 8/11/07 and was discharged on 9/28/07. The patient was a 66 year old male that was admitted to the hospital after being found unresponsive in his home. The patient's Braden scale on 8/13/07 was 9 (severe risk: supplement turning with small shifts in position, provide appropriate pressure reducing support surface, Certified Wound-Ostomy-Continence Nurse consult). The patient's medical records did not include documentation that he was provided with interventions as outlined in the Braden scale policy based on his admitting score of 9. Additionally, the "ACTIVITY Position" section of his EMTEK documented that he had not been repositioned every 2 hours or provided supplemental turning with small shifts in position.

It was further discovered that appropriate wound care had not occurred for his open pressure wound (cleanse with normal saline, use skin prep around wound edges, apply protective ointment twice a day, cover the wound with a foam or non-adherent dressing and change the dressings every 24 - 48 hours) in accordance with the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy. Lastly, a CWOCN was not contacted until 8/21/07 despite his low Braden scores (prior to the 8/23/07 score of 18) and having an open wound since 8/18/07. His medical records further documented that he was not repositioned every 2 hours or provided supplemental turning with small shifts in position despite the CWOCN nurse consult on 8/21/07 at 11:30 AM.

After the investigation, it was determined the hospital failed to provide adequate care for 8 of 18 patients on an ongoing basis in accordance with accepted standards of nursing practices and hospital's policies. The hospital's nursing staff failed to follow the hospital's "BRADEN SCALE for Predicting Ulcer Risk" policy interventions, and the "WOUND and PRESSURE ULCER-ASSESSMENT and CARE; CULTURE, IRRIGATION AND DEBRIDEMENT" policy and interventions. The cumulative effect of these negative facility practices resulted in harm to patients, and the potential for serious harm or death to occur.

Deficiencies were cited at 42 CFR 482.23 Condition of Participation: Nursing services for the failure of the hospital to ensure that nursing staff had adequately cared for patients on an ongoing basis in accordance with accepted standards of nursing practices and hospital's policies. The hospital provided a plan of correction. A follow up survey was completed and the hospital was found in compliance with all Conditions of Participation.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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